SelectCare POS Plan

Welcome

This Summary Plan Description outlines the SelectCare group health benefits plan provided by the State of Vermont. It describes your Benefits and explains plan eligibility, requirements, limitations and exclusions for coverage. The Table of Contents will guide you to information you may find helpful as you use the plan.

We encourage you to read this summary carefully and use it to make informed decisions for you and your covered family members. It is important to understand the terms and conditions of the health plan. If you have a question you cannot find the answer to in this summary, please call the Benefits Division office at (802) 828-0648 or (802) 828-3455.

Cynthia D. LaWare,
Commissioner of Personnel

How to Use This Summary

1. Chapter One is very important. Information in this chapter applies to all services provided by the plan.
2. The "Benefit Summary" on Page 6 identifies what Benefits and services may cost you.
3. Chapter Three describes Covered Services you may need. Please refer to the Index or Table of Contents for help in locating specific items.
4. The "Exclusions" section in Chapter Six explains which services are not covered.
5. The "Definitions" section in Chapter Nine describes and defines terms that are used throughout this summary to help explain your coverage. You will find these terms capitalized throughout the summary.

We know that you and your family will want to learn as much as you can about your health care program and the Benefits available to you. We hope this guide will help you.

Important

☞ **The State of Vermont intends that the terms of the plan described in this summary, including those terms related to coverage and Benefits, are legally enforceable, and that this plan is maintained for the exclusive benefit of members, as defined by law.**

Every effort has been made to make the information contained in this summary reflect the information contained in the detailed Plan Document. If any information in this summary is in conflict with the provisions of the Plan Document or the contracts established with administrators and insurers to provide Benefits, or if any provision is not covered or only partially covered in this summary, the terms of the Plan Document and the contracts will govern in all cases.

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Chapter 1: How the Plan Determines Your Benefits

General Guidelines

What is a Point of Service (POS) Plan and How Does It Work?

In a Point of Service plan, you decide whether or not to use a Provider or Hospital that has agreed to belong to the plan's network at the "point of service", each time you use a medical service. By agreeing to be in the plan's POS network, a Provider or a Hospital agrees to coordinate your care and provide that care at predetermined rates.

Under the SelectCare plan, you select a Primary Care Physician (PCP), who will coordinate your care. If the PCP decides that you need to see a specialist, you will receive a referral to a network specialist.

However, you also have the **freedom to choose** Providers who are not part of the network, or to seek care without a referral from your PCP. Your Cost Shares (Deductibles and Copays) are lowest when you visit Network Providers with referrals from your PCP, but you are still covered for visits to Out-of-Network Providers. If you visit a specialist or an Out-of-Network Provider without a referral, you will need to pay a Deductible and you will have a higher Cost Share than for visits coordinated by your PCP.

The SelectCare POS plan is not available to retirees who are Medicare eligible or who have dependents who are Medicare eligible, as the plan is unable to coordinate Benefits with Medicare at this time.

The SelectCare POS plan also provides the following services:

- Preventive care services are available to all Members.
- Emergency and Urgent Care is covered wherever you go, worldwide, 24 hours a day.
- 24-hour toll-free nurse hotline available 7 days a week. In addition, a library of hundreds of recorded programs on important health topics is available to you anytime, day or night.
- The Well-Aware Program for Better Health from CIGNA can help you manage chronic conditions such as diabetes and cardiovascular disease.
- The Healthy Babies program is available to provide health education and support for a healthy pregnancy.

What Providers Can You Use?

The term "Providers" is commonly used to describe those who provide health care services, including doctors and Hospitals. In health plans, Providers are either "Participating" or "Nonparticipating" in the plan's network. They may also be called "Network Providers". Participating or Network Providers agree to provide services to plan Members at negotiated rates. When you visit a Network Provider, the plan pays a greater share of the cost than if you visit an Out-of-Network Provider.

☛ **NOTE: Network Providers are in the United States only. Canadian Providers are not members of the plan's networks. Any non-emergency care sought or provided outside the United States, including in Canada, will be reimbursed at the lower out-of-network levels, after the annual $500 Deductible is met.**

Payment Terms

Allowed Amount

The amount that the Plan Administrator determines to be Reasonable and Customary for a covered service or supply.

When You Use In-Network Providers:

Copayment (Visit Fee)

There is no Deductible if you receive services from In-Network Providers. Most services are covered for a $15 Copayment. Providers may require payment at the time of service. You are responsible for paying Copayments to Providers as specified on the Benefit Summary on Page 6.

When You Use Out-of-Network Providers:

Deductible

For services received from Out-of-Network Providers, Deductibles must be met each calendar year before the plan pays Benefits.

There are two levels of annual Deductibles: individual and family. The individual Deductible is $500. Once the individual member meets a $500 Deductible each year, the plan pays Benefits. The family Deductible is $1,000. A family (Employee and one or more Covered Dependents) must pay $1,000 before Benefits begin. For the family Deductible, at least one family member must meet the $500 individual Deductible. Deductible amounts for remaining family members may be combined to meet the $1,000 family Deductible for the year.

Coinsurance

After your Deductible has been met, the plan pays 70% of the Eligible Expenses and the Member pays the remaining 30% Coinsurance. The maximum amount you must pay for Eligible Expenses in a calendar year after meeting your Deductible, is $2,000. Once this maximum payment is reached, the plan covers your Eligible Expenses at 100% for the balance of the calendar year. The family Coinsurance of $6,000 is the maximum amount a family is responsible for paying for Eligible Expenses incurred during a calendar year. Expenses for all family members may be combined to reach the $6,000 family maximum.

SelectCare Benefit Summary

SelectCare Benefit Highlights	In-Network	Out-of-Network
Primary Care Physician (PCP) Office Visit such as:	**Your cost is the copay with no annual medical deductible**	**The plan pays 70% after annual medical deductible**
Preventive Care/Well Care:		
Periodic Physical Exams (Children & Adults)	$15 Copay	70%
Routine Immunizations and Injections	$15 Copay	70%
Adult/Child Medical Care for Illness or Injury	$15 Copay	70%
Procedures performed in a Physician's Office	$15 Copay	70%
Routine Mammograms	Paid at 100%	70%
Specialist Office Visits such as:		
Consultations and Referral Physician Services	$15 Copay	70%
Well Care (Includes Pap Test and PSAs)	$15 Copay	70%
Procedures performed in Physician's office	$15 Copay	70%
Inpatient Hospital Services:		
Semi-Private Room and Board	$250 Copay per admission	70%
Physician Services		
Diagnostic/Therapeutic Lab and X-ray		
Drugs and Medication	***All inpatient hospital admissions require precertification. Call the toll-free number on your CIGNA HealthCare ID Card.***	***All inpatient hospital admissions require precertification. Call the toll-free number on your CIGNA HealthCare ID Card.***
Operating and Recovery Room		
Radiation Therapy and Chemotherapy		
Anesthesia and Inhalation Therapy		
Inpatient Surgeon's Charges	Paid at 100%	70%
Second Surgical Opinion	$15 Copay	70%
Outpatient Facility Services including:		
Operating Room, Recovery Room, Procedure Room and Treatment Room including:	Paid at 100%	70%
Physician Services		
Diagnostic/Therapeutic Lab and X-rays		
Anesthesia and Inhalation Therapy		
Outpatient Preadmission Testing		
Office Visit	Paid at 100%	70%
Outpatient Facility	Paid at 100%	70%
Laboratory and Radiology Services such as:		
MRIs, MRAs, CAT Scans and PET Scans	Paid at 100%	70%
Other Laboratory and Radiology Services		

SelectCare Benefit Summary Continued

SelectCare Benefit Highlights	In-Network	Out-of-Network
Short-Term Rehabilitative Therapy including Physical, Speech, Occupational and Chiropractic Therapies.	$15 Copay per office visit – **Maximum of 60 visits per year in aggregate.***	70% **Maximum of 60 visits per year in aggregate.***
Emergency and Urgent Care Services at:		
Physician's Office	$15 Copay	If true emergency, benefits are the same as the in-network benefits. If not a true emergency, benefits are paid at 70%.
Emergency Room, Urgent Care or Outpatient Facility	$50 Copay (waived if admitted)	
Ambulance	Paid at 100%	
Maternity Care Services		
Initial Office Visit to Confirm Pregnancy	$15 Copay	70%
All other office visits	Paid at 100%	70%
Delivery		
Hospital/Birthing Center Charges	$250 Copay per admission **Precertification required**	70% **Precertification required**
Physician Charges	Paid at 100%	70%
Inpatient Services at Other Healthcare Facilities including: Skilled Nursing, Rehabilitation and Sub-Acute Facilities	Paid at 100%. **60 days maximum per calendar year**	70% **Precertification required. 60 days max. per calendar yr.**
Home Health Services	Paid at 100%	70% **40 visits per calendar yr.**
Family Planning Services		
Office Visits (tests, counseling)	$15 Copay	70%
X-ray/lab if billed by separate facility	Paid at 100%	70%
Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	$250 per admission **Precertification required**	70% **Precertification required**
Outpatient Facility	Paid at 100%	70%
Surgery in Physician's Office	$15 Copay	70%
Infertility Treatment – Up to $50,000/lifetime		
Office Visits (tests, counseling)	$15 Copay	Covered in-network only
X-ray/lab if billed by separate facility	Paid at 100%	Covered in-network only
Treatment/Surgery (includes In-vitro Fertilization, Artificial Insemination, GIFT and ZIFT) done at an inpatient or outpatient facility or physician's office.	Paid at 100%	Covered in-network only
Durable Medical Equipment	Paid at 100%	70% **$700 Calendar year max.**

SelectCare Benefit Summary Continued

SelectCare Benefit Highlights	In-Network	Out-of-Network
External Prosthetic Appliances	Paid at 100%	70% **$1,000 Calendar year max.**
Vision Care	$100 every two calendar years, no deductible or coinsurance apply. Routine exams and lenses (excludes frames) are covered.	
Annual Deductible (Medical and Mental Health/Substance Abuse) Individual Family	 None None	 $500 $1,000
Annual Out-of-Pocket (OOP) Maximum (Medical Only) Individual Family	 None None	 $2,000 plus deductible $6,000 plus deductible
Coinsurance	None	The plan pays 70% of eligible charges after the annual deductible is met. You pay 30% of the charges after the annual deductible is met.
(Inpatient, Outpatient, and MRI's) Precertification required	Handled by your physician	Member must obtain approval prior to admission to a facility.
Lifetime Maximum	Unlimited	$2,000,000

* Out-of-network treatment maximums are reduced by in-network services used.

If you use a CIGNA Provider (In-Network Services):

► All services must be provided by or referred by your Primary Care Physician (PCP) in order to be covered except for: emergency services, routine care provided by a participating OB/GYN, and mental health and substance abuse services authorized by CIGNA Behavioral Health, Inc.

If you use a NON-CIGNA Provider (Out-of-Network Services):

► All out-of-network hospital admissions, outpatient surgeries and MRI's must be pre-certified by the member. To precertify, call the telephone number on the back of your ID card. Pre-certification **is not required** for emergency admissions.

► Benefits which are not covered out-of-network are: Organ Transplants, Infertility Treatment and Prescription Drugs.

► Once the out-of-pocket maximum for Out-of-Network services is reached, the plan pays 100% of Eligible Expenses for the remainder of the calendar year

Chapter 2: Membership

WHO IS ELIGIBLE?

State of Vermont

An Eligible Employee is:

- a classified or exempt permanent employee of the State of Vermont who is expected to work at least 1040 hours per calendar year;
- a member of the general assembly (legislators);
- a session employee of the legislature or the legislative council (3 V.S.A. § 635a).

State of Vermont Retirees

☛ **NOTE: The SelectCare POS plan is not available to retirees who are Medicare eligible or who have dependents who are Medicare eligible, as the plan is unable to coordinate Benefits with Medicare at this time.**

For the purposes of health eligibility, a retiree is defined as a state employee who ceases active state employment while covered under the plan and is determined to be eligible to continue health insurance per 3 V.S.A. § 631 or 3 V.S.A. § 500.

Coverage continued through COBRA is considered continued enrollment and is not considered an interruption in coverage.

A retiree who elects to continue coverage in retirement must have been a Member of the plan immediately prior to, up to and including the date of retirement. The only instance in which a break in coverage is allowed is in the case of a former employee who had coverage upon termination of employment, dropped coverage and was subsequently granted disability retirement. These employees will be eligible for coverage from the date they became disabled, as determined by the Retirement Board. However, they must apply for coverage within 60 days of the decision of the Retirement Board and they must make their Premium contribution retroactive to the date of disability. An Enrollment/Change Application must be submitted to change from COBRA coverage to coverage as a disabled retiree if the disabled retiree maintained COBRA coverage through the date of disability. Any Premium paid for coverage after the date of disability while awaiting the disability decision from the Retirement Board will be refunded back to the date of disability. Disabled retirees Premium contribution will be withheld from their disability pay retroactive to the coverage start date.

Employees who terminate employment and who are eligible to receive a pension at a later date (vested terminated employees) are not eligible for coverage upon termination except as described elsewhere in this summary (e.g., COBRA continuation coverage).

Special Groups

In addition to the individuals described above, permanent employees of the Vermont State Employees Association, Inc., the Vermont Historical Society, the Vermont State Employees Credit Union or the Vermont Council on the Arts who are expected to work at least 1040 hours per calendar year may be eligible to enroll in the plan. These groups are collectively referred to elsewhere in this summary as Special Groups.

Special Group Retirees

For the purpose of health plan eligibility, retirees are defined as employees of a Special Group identified in 3 V.S.A. § 631 who were covered by the plan when they ceased active employment with the Special Group and had: 1) 20 creditable years of service with the same Special Group, or 2) at least 15 years of creditable service with the same Special Group and had attained the age of 62. Retirees who do not continue enrollment in the plan upon retirement with no interruption in coverage between active employment and their status as a retiree, cannot elect to participate in the plan at a later date. (Coverage under COBRA is considered continued enrollment and is not considered an interruption in coverage.) Retirees who are not in the plan at retirement cannot enroll in the plan at a later date.

All of the individuals eligible for coverage identified in this section are collectively referred to as employees throughout the remainder of this summary.

Except as specified above, temporary personnel, contractual personnel, members of boards or commissions, persons whose compensation for service is not paid from the state treasury, and any elected or appointed official who is not actively engaged in and devoting substantially full time to the conduct of business of his public office are not eligible to participate in the plan (3 V.S.A. § 635).

Dependents

Dependents eligible for coverage include:

- legally married Spouse from whom the employee is not legally separated;
- Partner through civil union;
- Domestic Partner (Only Domestic Partners of active state employees are Eligible Dependents. State retirees and members of Special Groups may not enroll a Domestic Partner into the plan);
- unmarried dependent children under age 19 not on active duty in the uniformed services of any country;
- unmarried dependent children from age 19 to their 23rd birthday who are enrolled as full-time students at an accredited school where full-time student status is as defined by the accredited school;
- Incapacitated Children; and/or
- newborn children are covered automatically for 60 days following birth. However, newborn children of dependent children are not Eligible Dependents and are only covered for 31 days following birth.

Unmarried dependent child includes:

- a son, daughter and/or foster child who depends upon the Covered Employee for support and maintenance. If the child has coverage through any other plan including a state or federal plan, due to his or her status as a foster child, this plan will be secondary for Benefits to the other plan;
- a stepchild if such stepchild depends on the Covered Employee for most of his or her support and maintenance;
- other children who are dependent upon the Covered Employee for support and maintenance;
- the child of a Domestic Partner or Partner through civil union;

- children for whom the plan participant, Spouse, Partner through civil union or Domestic Partner has been appointed legal guardian by a court; and
- legally adopted children. A child will be considered legally adopted from the time the child is placed in the home for the purpose of adoption if the employee is legally obligated to provide full or partial support, whether or not a final adoption order has been issued.

Dependents are eligible for coverage if they are Eligible Dependents of employees who have elected coverage for themselves.

Coverage for Domestic Partners

The only Domestic Partners who may be covered under the plan are those of active state employees or those of a retired state employee if the Domestic Partner was covered before the state employee retired and coverage of the Domestic Partner has been uninterrupted. If coverage of a retired state employee's Domestic Partner is terminated, the Domestic Partner may not be reenrolled in the plan. Special Group active employees or retirees may not enroll Domestic Partners into the plan.

When an Employee and An Eligible Dependent are Both Eligible Employees

If an employee and a Spouse or Partner are both Eligible Employees, both may enroll as individuals or one may enroll the other as a dependent. If enrolled as individuals, out-of-pocket maximum limits will be determined independently for each Covered Employee. If each Eligible Employee enrolls as an individual, all children for whom coverage is elected must be enrolled by one Eligible Employee.

No individual may be covered under the plan both as an employee and as a dependent, nor may any Eligible Dependent be enrolled by more than one employee.

If, any Covered Child becomes an Eligible Employee while covered as a dependent, the Covered Child shall cease to be covered as a dependent as of the date the child is eligible to be covered as an employee.

Enrollment and Start of Coverage

Enrollment Is Required for Coverage

Enrollment is not automatic.

Employees and their Eligible Dependents may become covered under the plan only by submitting a completed Enrollment/Change Application to the Benefits Division.

ENROLLMENT UPON HIRE:

- Employees who desire coverage for themselves and their Eligible Dependents must enroll no later than 60 days after the Date of Hire (during the Initial Enrollment Period) by submitting a completed Enrollment/Change Application.
- Legislators must submit a completed Enrollment/Change Application within 60 days of taking office.
- Active employees enrolling a Domestic Partner must submit a completed and notarized Domestic Partner Application, in addition to a completed Enrollment/ Change Application.
- Employees enrolling Civil Union Partners must submit a tax declaration form in addition to an Enrollment/Change Application.

Start of Coverage

If the Benefits Division receives a completed Enrollment/Change Application within 30 days of an employee's Date of Hire (during the 30-day Waiting Period), coverage begins on the 31st day after the Date of Hire. If an employee does not enroll within 30 days of the Date of Hire, but enrolls within the next 30 days, coverage begins on the date the Enrollment/Change Application is received by the Benefits Division. Eligible Dependents coverage begins on the date the employee's coverage begins, if they are enrolled within the Initial Enrollment Period and their enrollment information is received with the employee's enrollment information.

If an employee enrolls after the 30-day Waiting Period but before the 60th day of employment, and the employee enrolls his or her dependents no later than the 60th day of employment, then coverage for the dependents will begin on the date the Enrollment/Change Application is received by the Benefits Division.

An employee may enroll and be covered without fulfilling the 30-day Waiting Period if the employee is covered under another group healthcare plan and the employee's coverage terminates during or immediately before the 30-day Waiting Period. "Immediately before" means up to three days before the Date of Hire. For example, the initial 30-day Waiting Period will be waived if prior coverage ends on a Friday and the Date of Hire is the following Monday or the next state business day.

Failure to Enroll During the Initial Enrollment Period

Employees who do not enroll during the Initial Enrollment Period will not be able to enroll themselves and any Eligible Dependent(s) until the next Annual Open Enrollment unless they and/or their Eligible Dependent(s) qualify for Special Enrollment as described on page 13.

ANNUAL OPEN ENROLLMENT

The Open Enrollment period is the month of November, unless otherwise mutually agreed upon by the State of Vermont and the Vermont State Employees' Association, Inc. (VSEA). Eligible Employees may make the elections outlined below during this time.

Elections Available Only During Open Enrollment

During the Open Enrollment Period, Eligible Employees may elect to:

- enroll themselves and Eligible Dependents in one of the plans for the first time;
- add Eligible Dependents to coverage if the employee is a Member of the plan; and/or
- elect a different plan.

☛ **Note:** Employees may terminate coverage for themselves and any Covered Dependents at any time. If employees discontinue coverage for themselves, coverage for their Covered Dependents will end at the same time.

Annual Open Enrollment is the only time an employee may change from one plan to another, unless he or she has a network-based plan, and permanently moves to an area that does not have that network.

Employees whose retirement date will be January 1 may not enroll during the Annual Open Enrollment, if they are not a Member of the plan at the time of the Annual Open Enrollment.

Restrictions on Elections During Open Enrollment

No Eligible Dependents may be covered unless the employee of whom they are dependents is covered.

All relevant parts of the Enrollment/ Change Application must be completed and the application must be received by the Benefits Division on or before the last day of the Annual Open Enrollment Period.

Retirees who are not Members of the plan may not participate in Annual Open Enrollment. Retirees who are Members of the plan may not add dependents during Open Enrollment.

Coverage Following Open Enrollment

Coverage elections or changes made during any Annual Open Enrollment will become effective on January 1 of the following year.

If You Do Not Change Plans During Open Enrollment

If you are enrolled in one plan and do not change plans during the Annual Open Enrollment period, you will remain in your current plan.

If You Do Not Enroll During Open Enrollment

If you or your Eligible Dependents are not enrolled in a health plan prior to the Annual Open Enrollment, and do not join a plan during the Annual Open Enrollment, enrollment will not be available until the next Annual Open Enrollment period, unless you or your Eligible Dependents qualify for Special Enrollment.

SPECIAL ENROLLMENT

Newly Acquired Eligible Dependent

If a Covered Employee acquires an Eligible Dependent through a qualifying event such as marriage, Civil Union, Domestic Partnership, birth, or adoption, the Eligible Dependent may be enrolled no later than 60 days after the date he or she became an Eligible Dependent. However, a retired employee may not add a Domestic Partner.

Active employees who are not covered and who acquire an Eligible Dependent through a qualifying event may enroll themselves and their new Eligible Dependent and any other Eligible Dependents no later than 60 days after the qualifying event.

If an active employee did not enroll his or her Spouse or Partner for coverage within 60 days of the date on which the Spouse or Partner became an Eligible Dependent, and if the employee subsequently has a qualifying event through which he or she acquires an Eligible Dependent child, the Spouse or Partner together with the new dependent child may be enrolled no later than 60 days after the date the child became an Eligible Dependent (e.g., date of birth or date on which child was placed for adoption). In this case, employees do not have to be enrolled prior to enrolling a Spouse or Partner or a child, but employees must enroll themselves to enroll the Spouse or Partner or a child.

If a retiree who is a member of the plan did not enroll his or her Spouse or Civil Union Partner for coverage within 60 days of the date on which the Spouse or Civil Union Partner became an Eligible Dependent, and

the retiree subsequently acquires a child who is an Eligible Dependent, the Spouse or Civil Union Partner and the newly acquired dependent child may be enrolled no later than 60 days after the date the child became an Eligible Dependent (e.g., date of birth or date on which child was placed for adoption).

Dependent children who are adopted or are in placement awaiting adoption and who are enrolled within 60 days of adoption or placement for adoption, will be eligible for coverage from the date the child is adopted or placed for adoption with the employee. In no instance will coverage be retroactive more than 60 days from the date the Benefits Division receives the Enrollment/Change Application. A child is considered placed for adoption on the date the employee becomes legally obligated to provide full or partial support while the employee is in the process of adopting the child. However, if a child is placed for adoption, and if the adoption does not become final, coverage of that child will terminate as of the date the employee no longer has a legal obligation to support that child.

Start of Coverage Following Special Enrollment

- **Newborn Children of an Enrolled Employee**
  A newborn child of an enrolled employee is covered from birth to 60 days of age without any enrollment action required. However, the employee must enroll the child within 60 days of birth to obtain coverage beyond 60 days.
- **Newborn Children of a Covered Child**
  A newborn child of a Covered Child is covered for 31 days but is not an Eligible Dependent.
- **Adopted Children**
  Adopted or placed children are covered for 60 days from date of birth, placement or adoption, but this coverage is not automatic. The Benefits Division must receive an Enrollment/Change Application within 60 days of birth, placement or adoption for coverage to be effective as of the date of birth, placement or adoption, respectively.

Loss of Other Coverage

Employees may enroll themselves and/or their Eligible Dependents (as long as the employee is enrolled) within 60 days after the termination of coverage under another health plan if:

- enrollment did not occur within 60 days after the date the employee or the Eligible Dependents first became eligible for coverage because the employee or the Eligible Dependents had healthcare coverage under another health plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid, TRICARE or other public program; **and**
- the employee and/or any Eligible Dependents lose coverage from the other health plan through no fault of their own, including exhaustion of COBRA coverage, death of a Spouse, Domestic Partner or Civil Union Partner, divorce, dissolution of a Domestic Partnership or civil union, or loss of a job.

COBRA continuation coverage is exhausted if it ends for any reason other than: 1) the failure of the individual to pay the applicable COBRA Premium on a timely basis, or 2) for cause (e.g., making a fraudulent claim), or 3) a permanent move to an area that is not a service area of the COBRA HMO.

Failure to Enroll During Special Enrollment

If employees fail to enroll themselves and/or any Eligible Dependents, including newborn children, within 60 days after the date on which they first become eligible for Special Enrollment, they will not be able to enroll themselves and/or any Eligible Dependents until the next Annual Open Enrollment period.

RETURN TO WORK

- **Reduction In Force (State Employees only)**
  Former state employees who were laid off in a Reduction in Force (RIF) and did not maintain coverage may enroll themselves and their Eligible Dependents in the plan within 60 days of return to active state service by exercising their RIF rights if they meet the eligibility requirements. In this instance, there is no 30-day Waiting Period.

  Employees must re-enroll in the same plan they had prior to being laid off if that plan is still available, unless they have missed the opportunity to change plans during an open enrollment which occurred while they were laid off. If they missed an Annual Open Enrollment period, they may re-enroll in a different plan. Eligible Dependents may be enrolled regardless of whether they were previously enrolled. If an employee did not have coverage at the time of the layoff, the employee may enroll as a new hire upon return to active state service through exercise of RIF rights. However, they are subject to a 30-day Waiting Period.

- **Parental and Family Leave or Military Leave (all Employees)**
  Employees on Parental and Family Leave (21 V.S.A. § 470 et. seq. and 29 U.S.C. §2601 et. seq.) or Military Leave whose coverage ended while on leave may have coverage reinstated upon return to work if they return promptly at the end of that leave and elect to reinstate coverage. They must enroll in the same plan they had prior to going on leave status unless they have missed the opportunity to change plans during an Annual Open Enrollment which occurred while on leave status. If they missed an Annual Open Enrollment period, they may re-enroll in a different plan. Eligible Dependents may be enrolled whether or not they were previously enrolled.

- **All other Leaves of Absence (all Employees)**
  Any employee on an approved leave of absence (medical or non-medical, paid or unpaid), or any permanent employee who dropped coverage while on a leave or during inactive status may not be reinstated upon return to active status if they dropped coverage during the inactive status. The employee must wait until the next Annual Open Enrollment period unless the employee experiences a qualifying event. Even though an employee dropped coverage during a leave of absence, the period without coverage will not be counted as a break in coverage as required by state or federal laws (e.g., Vermont Parental and Family Leave law and the Uniformed Services Employment and Re-employment Act).

Qualified Medical Child Support Orders (QMCSOs)

According to federal law, a Qualified Medical Child Support Order, or QMCSO, is a child support order of a court or state administrative agency (usually resulting from a divorce or legal separation) that has been received by the plan, and that:

- designates one parent to pay for a child's health plan coverage;
- indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- contains a reasonable description of the type of coverage to be provided under the designated parent's healthcare plan or the manner in which such type of coverage is to be determined;
- states the period for which the QMCSO applies; and
- identifies each healthcare plan to which the QMCSO applies.

An order is not a QMCSO if it requires the plan to provide any type or form of benefit or any option that the plan does not provide, or if it requires an employee who is not covered by the plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to healthcare coverage for an Eligible Dependent of an employee, the Plan Administrator will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the employee is covered by the plan, the Plan Administrator will notify the parents and each child to be covered, and advise them of the procedures that must be followed to provide coverage.

If the employee is a participant in the plan, the QMCSO may require the plan to provide coverage for the employee's Eligible Dependents who are children and to accept contributions for that coverage from a parent who is not a plan participant. The plan will accept a Special Enrollment of the dependent child(ren) specified by the QMCSO from either the employee or the custodial parent. Coverage of the child(ren) shall become effective as of the date the enrollment is received by the plan, and shall be subject to all terms and provisions of the plan, including the limits on selection of Provider and requirements for authorization of services, insofar as is permitted by applicable law.

If the employee is not a participant in the plan at the time the QMCSO is received and the QMCSO orders the employee to provide coverage for the Eligible Dependent child(ren) of the employee, the plan will accept a Special Enrollment of the employee and the child(ren) specified by the QMCSO. Coverage of the employee and the child(ren) shall become effective as of the date the Enrollment/Change Application is received by the plan, and shall be subject to all terms and provisions of the plan.

No coverage will be provided for any child(ren) under a QMCSO unless the applicable employee contributions for that child's coverage are paid, and all of the plan's

requirements for coverage of that child have been satisfied. Contributions required for coverage under a QMCSO are the total employer contributions required for coverage of the employee and all members of the employee's family who are enrolled in the plan, minus the contributions being paid by the employee.

Coverage of a dependent child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions. The dependent child's may exercise the right to elect COBRA continuation coverage if that right applies.

Removing Dependents

You must remove dependents from your plan if any of the following events occurs:

- the dependent dies;
- the employee and Spouse and/or Civil Union Partner divorce;
- the employee and Domestic Partner dissolve a domestic partnership;
- a child no longer meets the definition of a dependent (marries, turns age 19, etc.);
- an Incapacitated Child is no longer incapacitated; or
- a child no longer meets the definition of a full-time student.

In any of these events, employees must complete an enrollment form to remove the dependent from their plan. Otherwise, the employee may continue to pay Premium contributions for that dependent even though the coverage has ended. No Refunds are allowed. The plan requires this action even if the change will not effect the type of coverage (i.e., two person or family).

Termination of Group Coverage

Events Causing Coverage to End

Coverage ends: 1) on the last day of the bi-weekly pay period in which employment ends; 2) when an employee is no longer eligible to participate in the plan; or 3) when an employee ceases to make any contributions required under the plan for coverage.

If the employee elects to cease making payments and notifies the Benefits Division by submitting an Enrollment/Change Application, coverage will be terminated: 1) at the end of the pay period in which the Enrollment/Change Application is received by the Benefits Division if the employee is in active service of the state, or 2) at the end of the month in which the Enrollment/Change Application is received by the Benefits Division if the employee is not in active service of the state.

If a Member ceases to make the total contribution required for coverage by the due date of that contribution and does not notify the Benefits Division by submitting an Enrollment/Change Application, coverage will be terminated 31 days after the due date, but no earlier than 14 days from the date the Benefits Division has mailed a notice of the termination to the last address the employee provided to the Payroll Division.

If eligibility for continued participation in the plan ceases because the number of hours a permanent employee is expected to work in the calendar year is less than 1040 hours, the employee will be given reasonable notice regarding termination of coverage and the opportunity to have a hearing before the Commissioner of Personnel.

Coverage of Covered Dependent(s) ends: 1) on the last day of the bi-weekly pay period in which the employee's employment ends; 2) when a Covered Dependent no longer meets the definition of Eligible Dependent; or 3) when the employee ceases to make any contributions required for the Covered Dependent's coverage.

To terminate coverage for any reason other than termination of employment, an Enrollment/Change Application must be filed with the Benefits Division no later than the end of the pay period in which the qualifying change occurs, or when termination is desired. Late filing of an Enrollment/Change Application may result in payment for coverage that has been terminated automatically by the plan (e.g. over-age dependent child). **No refunds of overpaid Premiums are allowed.**

Special Circumstances

- **Parental and Family Leave**
  Full-time employees who have successfully completed original probation or have worked for one year, are entitled, by state and federal law, to up to 12 weeks of unpaid Family and/or Parental Leave each 12-month period beginning with the first day either type of leave is used for family or medical purposes specified in state or federal law (e.g., personal illness, birth or adoption of a child, or provision of care to a Spouse, child or parent who is seriously ill). However, the labor agreement between the State and VSEA allows for four months of parental leave which includes the 12 weeks of statutory parental leave. (The amount of leave for part-time employees is calculated on a prorated basis consistent with 29 C.F.R. 825.205.) Employees on such a leave may keep coverage for themselves and their Covered Dependents in effect during the leave period by continuing to pay contributions each payday.

  Regardless of whether an employee keeps coverage while on Parental and/or Family Leave, if the employee returns to work promptly at the end of that Leave, his or her coverage and that of any dependents who were covered by the plan at the time Leave was taken will be reinstated without any additional limits or restrictions imposed due to the Leave. Any changes in the plan's terms, rules or practices that went into effect while the employee was away on Leave will apply to the employee and Covered Dependents in the same way they apply to all other employees and their Covered Dependents.

- **Leave for Military Service**
  If an employee goes into active military service, coverage will continue through the end of the pay period in which leave for military service begins. The employee may continue coverage for themselves and their Covered Dependents if the employee continues to pay contributions each payday. Employees who drop coverage while on military leave may reinstate coverage in the plan upon return to state employment.

- **Leave to Serve in General Assembly**
  Employees on an unpaid leave of absence for service in the General Assembly may remain in the plan for the approved period of leave if they continue to pay their contribution each payday. Failure to pay their contribution will result in cessation of coverage at the end of the last pay period for which a contribution was made.

- **Reduction in Force (RIF)**
  Employees in a RIF status who retain reemployment rights under the Reemployment Rights Article of the negotiated union agreement may continue coverage for up to two years from the effective date of separation, subject to contribution levels specified in the collective bargaining agreements.
- **Approved Leave of Absence Other than Parental/Family, or Military Leave**
  Employees on approved, unpaid leave of absence, other than Parental, Family or Military Leave, including leave of absence for medical reasons that exceeds 12 weeks, and employees who are permanent part-time employee in an inactive status, may remain in the plan for the approved period of leave or inactive status as long as they continue to pay contributions on or before each pay date for which the payroll deduction of Premium would normally be made.

Extension and Continuation of Medical Coverage

Under certain circumstances, employees may be able to continue medical coverage at their own expense for a limited period of time after an event that would have otherwise terminated coverage. See following for an explanation of when and how these circumstances may apply to coverage.

Ending or Continuing Coverage

This plan does not provide plan Benefits for any medical expenses incurred after coverage ends. However, under certain circumstances:

- a Member's coverage may be extended for certain expenses after coverage ends; and
- a Member's coverage may be continued.

This section explains when and how this extension and continuation of coverage occurs.

Extension of Coverage During Total Disability or Hospitalization

If coverage ends because of termination of employment, and if on the last date of coverage:

- a Member is Totally Disabled (as defined in the Definitions section of this summary), or hospitalized, and
- the disabled person or hospitalized person is not otherwise covered by Medicare or by any other group or individual health insurance policy or healthcare plan,

then Benefits will be extended for the hospitalized or disabled person. In the case of disability, Benefits for the medical condition causing the Total Disability of the disabled person will be extended for the disabled person, subject to the terms and provisions of this plan, for up to 12 months after coverage ends, provided the disabled person continues to be Totally Disabled. If the disabled person becomes covered by any other group or individual healthcare insurance policy or healthcare plan or by Medicare, the extension of coverage will cease if that coverage provides Benefits to the disabled individual.

In the case of hospitalization, Benefits for the hospitalized person will be extended, subject to the terms and provisions of this plan, as long as the person remains hospitalized for the condition for which they were admitted or a complication of that condition, for the duration of the hospitalization or 52 weeks, whichever is less. If the hospitalized person becomes covered by any group or individual healthcare insurance policy or healthcare plan or by Medicare, the extension of coverage will cease if that coverage provides Benefits to the hospitalized individual.

The plan reserves the right to have a Member claiming Total Disability examined by a physician selected by the plan at any time during the period that Benefits are extended under this provision. The cost of such an examination will be paid by the plan.

The extension of coverage does not apply to the expenses of a child born as a result of a pregnancy that exists when coverage terminates.

Continuation of Coverage

► **Death of an Employee or Retiree**

Covered Dependents of a deceased employee, who receive a monthly survivorship payment from the state, may continue medical coverage under the Plan's rules provided that:

- the deceased retiree did not retire due to a disability, or
- the deceased retiree retired due to a disability prior to January 2, 1998.

Once such a Member discontinues coverage, they may not elect coverage under the plan at a later date. Surviving Covered Dependents of an employee (active employee or retiree) who will not receive a monthly survivorship payment may continue coverage for 36 months under COBRA (see next paragraph).

► **COBRA Continuation Coverage**

COBRA (Consolidated Omnibus Reconciliation Act of 1986) is a federal law. It allows employees and/or their Covered Dependents to continue health coverage by paying 102% of the Premium costs, after it would normally end for any of the following reasons: job termination, reduction in force (RIF), death, divorce, or dependents reaching the limiting age (which makes them ineligible for coverage). **Please note that COBRA does not apply to non-qualified Domestic Partners or children of Domestic Partners because they are not considered legal dependents under the governing rules and regulations of the Internal Revenue Service.** Coverage may be continued for up to 18 or 36 months depending upon the reason coverage is ending. Coverage may only continue in the same medical plan that was in effect prior to the COBRA event. This plan is in compliance with federal law regarding COBRA. A summary of the features of the law is provided below. Detailed information can be found in the Plan Document or by contacting the Benefits Division. If this summary conflicts with federal law regarding COBRA, federal law applies.

► **Options Under COBRA**

- **Termination by Reduction in Force (RIF):** You may elect to continue coverage for up to 18 months for yourself and your Covered Dependents. If the Social Security Administration determines that you were disabled at the time of termination by RIF, coverage may be extended up to 29 months in total. Information will be sent to you automatically by the Plan Administrator.
- **When a Child Reaches the Plan's Age Limit:** Coverage may be continued for up to 36 months. Information will be sent to you by the Plan Administrator once they have been notified that your Covered Dependent is no longer eligible for coverage.
- **Divorce or Employee's Death:** In the event of divorce or death of the employee, the divorced Spouse or any Covered Dependent who survives the deceased employee may elect to continue coverage for up to 36 months. Information will be sent to you by the Plan Administrator once they have been notified of the divorce or death.

► **Coverage Provided When COBRA Continuation Coverage Is Elected**

If a Member chooses COBRA Continuation Coverage, the plan is required to provide coverage that is identical to the current coverage under the plan that is provided for similarly situated employees or Eligible Dependents.

► **Cost for COBRA Continuation Coverage**

Members pay 102% of the full cost of the coverage during the COBRA continuation period. The amount is payable monthly. There will be an initial grace period of 45 days to pay the first Premium starting with the date continuation coverage was elected. There is a grace period of 31 days after the due date to pay any subsequent Premium due. If Premium payment is not received by the end of the applicable grace period, the COBRA continuation coverage will terminate.

► **Termination of COBRA Continuation Coverage**

COBRA Continuation Coverage may be terminated if:

- the State of Vermont no longer provides any medical coverage to any of its similarly situated employees;
- the applicable Premium for COBRA Continuation Coverage is not paid on time or within the grace period;
- the covered individual is or becomes entitled to Medicare; or
- the covered individual is or becomes covered under another group health plan that does not contain an exclusion or limitation that applies to any pre-existing condition of the covered individual.

► **Other Information about COBRA Continuation Coverage**

If the coverage provided by the plan is changed in any respect for active plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that

increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

► **Continuation Coverage if not Eligible for COBRA**

Vermont law (8 V.S.A. § 4090) requires employers with group health plans to offer employees and their Covered Dependents the opportunity to temporarily continue their healthcare coverage at group rates for up to six months when coverage under the plan would end due to the employee's termination of employment, the employee's death, divorce or legal separation of the Covered employee from the employee's Spouse, dissolution of a Civil Union Partnership with the employee, dissolution of a Domestic Partnership with the employee, or a dependent child ceasing to be a dependent child.

To obtain more information regarding this option, contact the Benefits Division.

Proof Of Coverage

When coverage ends, a Certificate of Creditable Coverage will be provided for each former Member indicating the period of time they were covered under the plan. If, within 62 days after coverage under this plan ends, a former Member becomes eligible for coverage under another group health plan, or buys a health insurance policy, this certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply. The certificate will indicate the period of time covered under this plan, and certain additional information that is required by law.

The provision of certificates is mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This plan is in compliance with federal law regarding HIPAA. If this summary conflicts with federal law regarding HIPAA, federal law applies.

Chapter 3: Covered Services and Supplies

Hospital Inpatient Services

☛ Note: All scheduled admissions to any facility require preadmission certification.

The plan covers Eligible Expenses for Inpatient care in a Hospital, including:

- semi-private room (a room with two or more beds);
- private room only if the Hospital has no semi-private rooms or if a bed in a private room is Medically Necessary (e.g., patient has a contagious illness);
- facility services (operating room, medications, anesthesia and other Medically Necessary Hospital services and supplies);
- professional services (general nursing care and physician care); and
- related supplies.

Items Not Covered

The following items are not covered:

- private room unless Medically Necessary,
- television,
- telephone, and
- any personal comfort items.

Hospital Outpatient Services

Emergency Room Services

An emergency room should be used only in the event of an Emergency Medical Condition. An Emergency Medical Condition is defined in Chapter 9.

Members must notify the plan within 48 hours of an emergency admission or as soon as reasonably possible. In addition, members must notify their Primary Care Provider of all emergency room visits.

Other Hospital Outpatient Services

The following services and supplies are covered:

- Outpatient surgery (operating room, procedure room, recovery room and other Medically Necessary Hospital services and supplies);
- observation stay;
- casts, splints and braces;
- physical, speech and occupational therapy;
- diagnostic services;
- laboratory tests and imaging studies (e.g., x-rays, ultrasounds, MRIs, etc.); and
- routine screenings including: mammograms, colonoscopies and prostate exams.

Ambulatory Surgical Care

The plan covers services provided in an Ambulatory Surgical Care Facility, including laboratory tests, radiology services and casts/splints/braces.

Diagnostic Services

Diagnostic services used to detect symptoms or identify an illness or injury are covered. These services may be performed in the Outpatient department of a Hospital, doctor's office or other setting. Covered services include but are not limited to: radiological studies; laboratory and pathology tests; diagnostic medical studies such as ECGs, EEGs and EKG; and allergy testing.

Physician's Services

The following are covered physician services:

- office visits for diagnosis and treatment of an illness or injury;
- surgery done on an Inpatient or Outpatient basis;
- care associated with an Emergency Medical Condition;
- Medically Necessary injections;
- consultations ordered by the attending physician of a Member who is hospitalized;
- visits from the attending physician while a Member is hospitalized, and
- immunizations, well child care and routine preventative exams (physicals).

Second and Third Opinions

Members must call the plan to obtain authorization for the second opinion. Once authorized, second surgical opinions are covered when obtained from a physician who is qualified to treat the diagnosis, injury or sickness.

If the second opinion differs from the initial recommendation, the plan will cover a third opinion from a qualified physician.

Maternity and Family Planning Services

The following are covered maternity and family planning services:

- Care for a routine pregnancy, including prenatal and postnatal medical care visits and delivery services. You must notify the Plan Administrator within 24 hours after your maternity admission or as soon as reasonably possible. This includes care due to complications of pregnancy and caesarean sections.
- Services associated with a miscarriage or an elective termination of pregnancy.

In accordance with Vermont law, these services are provided to all plan Members, including dependent children.

Infertility Services

Benefits are payable for the services listed below in conjunction with either in-vitro or in-vivo fertilization:

- diagnostic work-up and evaluation;
- ongoing drug therapy;
- laboratory studies, including ultrasound;
- surgery to extract and/or fertilize mature eggs (Inpatient or Outpatient);
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- counseling;
- drugs administered or provided by a Participating Provider, and
- covered drugs obtained directly by the Member.

The plan does not cover donor-related services or specimens or any experimental or investigational infertility procedures or therapies.

☛ **Note:** This infertility services benefit has a Limited Lifetime Maximum Benefit of $50,000 for services described herein. A separate Limited Lifetime Maximum Benefit of $20,000 applies to drug costs associated with infertility services when the drugs are obtained through or reimbursed by the plan's pharmacy benefits manager.

The plan does not cover infertility services which are obtained out-of-network.

Other Covered Services

Vasectomies and tubal ligations.

Reversals of sterilizations are not covered.

Gynecological Care

Benefits are provided for routine preventive as well as Medically Necessary gynecological care. The plan covers two visits per calendar year to an In-Network gynecological healthcare Provider and follow-up care for problems identified during such visits, without a referral from a Primary Care Provider.

Home Health Care

Home health care services are covered when the following requirements are met:

- The services must be for Acute Care and provided in the Member's place of residence or other approved setting.
- The Member's physician must certify and the Plan Administrator must agree that:
  - the services cannot be provided on an Outpatient basis in a doctor's office or at a Hospital (i.e. the Member is homebound),
  - the services are for Acute Care, not Chronic Care, and
  - if the Member did not receive these services, they would be admitted to a Hospital or skilled nursing facility.
- The Member's doctor must re-certify care every 60 days or as otherwise required by the plan; however no more frequently than every 60 days.

Home Health Care services include:

- skilled nursing services for part-time care by a registered nurse or a licensed practical nurse (includes training of family members or other caregivers);
- home health aide services for care when the Member is also receiving nursing services from a registered nurse or licensed practical nurse or receiving physical or occupational therapy services; and
- physical, occupational or speech therapy (subject to any Annual Maximum Benefits or limitations for short term rehabilitative therapy).

Home Health Care services **do not include:**

- Chronic Care;
- homemaker services;
- dietician services;
- maintenance therapy unless approved under a plan of care;
- Custodial Care, or
- food or home delivered meals.

Hospice Care

Hospice care is a coordinated plan for palliative and supportive care at home or in a special facility for patients who are terminally ill. The plan provides care to meet the physical, psychological, spiritual and social needs of dying persons and their families during the final stages of a terminal illness and during bereavement. A professional team made up of trained medical personnel, homemakers, and counselors provides care. To qualify:

- a physician must certify that the patient is terminally ill and has no more than a six-month life expectancy;
- the agency providing hospice care must be certified by Medicare or licensed in the state in which the hospice is located. In Vermont, operation by a home health agency which is certified by Medicare also qualifies a hospice Provider for this Benefit;
- a primary caregiver must be available to be in the home, and
- both the patient and physician must consent to the hospice care plan.

Covered charges include:

- part-time or intermittent nursing care by or under the supervision of a registered nurse;
- part-time or intermittent services of other healthcare professionals who are reimbursable under this plan (e.g., physical therapists, speech therapists or occupational therapists);
- physician services;
- services of a psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- laboratory tests, and
- bed, board, services and supplies in a hospice facility.

Hospice Benefits **are not provided** for:

- services provided by relatives by blood or marriage, Civil Union or Domestic Partnership, or charges by a person who lives in the household of the terminally ill Member;
- charges by individuals who do not regularly charge for their services;
- periods during which the terminally ill Member is not under the care of a physician;
- curative or life-prolonging procedures; and
- services or supplies that are primarily to aid the terminally ill Member and other household members in daily living.

Ambulance Services

Air or ground Ambulance transportation for:

- transportation from the scene of an accident or medical emergency, to the closest facility that can provide the Medically Necessary services required, and
- transportation from home/to home or between medical facilities when Medically Necessary and ordered by a physician.

Chiropractic and Short Term Rehabilitative Therapy

Medically Necessary short-term rehabilitative therapy will be covered when provided in an Outpatient or home setting.

Benefits for physical, occupational and speech therapy and chiropractic care are provided only if the therapy is performed by a licensed or certified physical, occupational or speech therapist or chiropractor. If a state requires licensure for a profession, certification is not sufficient. These services require a referral. In addition, Providers may be required to submit a treatment plan after a specified number of visits. The treatment plan must be approved before additional visits will be considered for payment.

Benefits will not be provided for therapy services to treat chronic pain control, developmental, pulmonary or other forms of rehabilitative services.

Covered services are described below:

Physical Therapy

Therapy to relieve pain of an Acute Condition, restore function or prevent disability following disease or injury.

Occupational Therapy

Therapy to promote the restoration of a covered person's ability to perform the ordinary tasks of daily living or the requirements of a job.

Speech Therapy

Therapy to correct swallowing defects and speech impairment caused by an accident, illness or surgical procedure.

Chiropractic Care

Medically Necessary physiotherapy modalities and rehabilitative exercises for the restoration of motion, reduction in pain and improvement in function.

Benefits are payable for office, home or residential treatment facility visits and include diagnostic x-rays of the spine.

The following services billed by a chiropractor are not covered:

- operative or cutting procedures;
- surgical treatment of fractures, dislocations or other accidental injuries;
- obstetrical procedures (includes prenatal adjustments);
- prescription or administration of drugs (includes over-the-counter drugs, vitamins, supplements, homeopathic preparations, etc.);
- laboratory tests;
- ultrasound tests, acupuncture, colonics and transcutaneous electrical nerve stimulation; and
- treatment of any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs.

Cardiac Rehabilitation

This benefit covers cardiac rehabilitation after a heart attack (myocardial infarction), a cardiac procedure (by-pass, angioplasty, etc.), or after being diagnosed with coronary artery disease. Covered services include:

- nursing services;
- physical therapy;
- education, and
- up to three supervised cardiac rehabilitation exercise sessions per week for up to 12 weeks.

Cardiac Rehabilitation services require Prior Authorization from the Plan Administrator.

Other Therapy Services

In addition to the therapy Benefits described above, Benefits are payable for:

- radiation therapy (e.g., radium; radioactive isotope therapy, etc.);
- chemotherapy;
- infusion therapy, and
- dialysis treatment.

Home Infusion Therapy

Benefits are provided for the following services and supplies delivered in a Member's home:

- chemotherapy;
- intravenous antibiotic therapy;
- total parenteral nutrition;
- enteral nutrients through a feeding tube (when it is the sole source of nutrition);
- hydration therapy;
- intravenous/subcutaneous pain management, and
- other infusion-related Medically Necessary therapies.

In addition, Benefits are provided for the following services and supplies associated with home infusion services:

- solutions and pharmaceutical additives;
- pharmacy compounding and dispensing services;
- Durable Medical Equipment;
- ancillary medical supplies, and
- nursing services including patient and/or caregiver training, monitoring of intravenous therapy regimen and skilled nursing care.

Benefits are only provided if a physician prescribes a home infusion therapy regimen and Prior Approval is obtained.

No Benefits are payable for nursing services to provide or administer therapy that a patient or a caregiver is typically trained to administer. Some services (e.g. pharmacy supplies and Durable Medical Equipment) may be subject to limitations specified elsewhere in this summary.

Prescription Drugs

The plan covers prescription drugs obtained at a network pharmacy or from the Plan's mail order pharmacy. Initial prescriptions and refill prescriptions obtained from a retail pharmacy are limited to a 30-day supply of medication. The mail order prescription drug program is designed to be used for long-term maintenance medications that are taken for at least 90 days at a time. A 90-day supply may be obtained from the mail order pharmacy.

There is an annual Deductible of $25 per Member with a maximum of $75 per family, which is separate from the medical plan Deductible. Once this Deductible has been met, the plan pays 80% of the cost of generic drugs or brand name drugs when no chemically equivalent generic drug is available.

If a brand name drug is ordered when a chemically equivalent generic drug is available, the prescription will be filled with the generic drug. If a brand name drug is shown to be Medically Necessary for a member, the generic substitution provision is waived. If a brand name drug is requested by a Member but is not Medically Necessary, the Member must pay the difference between the brand name drug and the equivalent generic drug as well as any applicable deductible and 20% Coinsurance.

Please refer to the Prescription Drug Schedule of Benefits on the following page for additional information, limitations and restrictions.

Prescription Drug Schedule of Benefits

Benefit Feature	Description of Managed Pharmacy Benefit
Annual Deductible	$25/Member, maximum of $75/family. For both retail and mail order combined.
Coinsurance	20% for brand and generic drugs
Maximum Annual Out-of-Pocket Expense Per Member	$325/year ($25 Deductible and $300 in Coinsurance). Retail and mail order Coinsurance is combined. The plan pays 100% for Eligible Expenses for the rest of the calendar year after the Member pays $325.
Prescription Supply	- 30 days for retail prescriptions - 90 days for mail order prescriptions **Note:** Exception to the 30-day retail supply available for extended vacations and business trips. Two exceptions per year and a maximum supply per exception of 90 days.
Pharmacy Network	Retail: PerxSelect, the largest Express Scripts network, 53,000 pharmacies Mail Order: Express Scripts No Benefit provided for prescriptions obtained from a U.S. retail or mail order pharmacy that is not in the network.
Drugs Not Covered	- Yocon - Renova - Propecia and other hair loss products - Vaniqa and other hair removal products - Drugs that may be purchased without a prescription such as vitamins, minerals, food supplements (exceptions: Claritin, Alavert and smoking cessation products when prescribed by a physician)
Mail Order Restrictions	Relenza and Tamiflu only available at retail drug stores
Replacement Prescriptions	One prescription/year replaced if lost, destroyed or stolen (If you have two prescriptions and both are stolen, each prescription will be replaced once in a year.)
Contraceptives	Drugs (including injectables) and devices (e.g., IUDs, estrogen rings and diaphragms) are covered by the pharmacy benefit. Only one cycle of birth control pills dispensed per visit to a retail pharmacy.
Self-administered Injectables	Covered if drug is self-injected the majority of times it is administered (injectables usually injected by a medical professional are covered under the medical benefit)
Infertility drugs	Lifetime maximum of $20,000, includes oral and injectable drugs

Continued on next page

Prescription Drug Schedule of Benefits Continued

Benefit Feature	Description of Managed Pharmacy Benefit
Diabetic drugs and supplies	Covered under the pharmacy benefits, includes insulin, syringes, needles, alcohol swabs, test strips, ketone tablets, lancets and lancet devices which assist in the drawing of blood samples.
Prior Authorization	Required for: - Cerezyme - DDAVP/Stimate (vasopressin) - Epogen - Procrit - Prolastin - growth hormones - Lamisil - Sporanox - appetite suppressants (includes Meridia and Xenical) - Retin A (if over 30 years of age) - Differine (if over 30 years of age) - Avita (if over 30 years of age) A physician or a pharmacist may request Prior Authorization by phone or letter. Authorization may be backdated one month.
Foreign Prescriptions	Covered at above cited benefit levels if drug is approved by the FDA. Member must submit a claim to Express Scripts.

Durable Medical Equipment

Benefits are paid for most Medically Necessary supplies and for the rental and/or purchase of Durable Medical Equipment, which is:

- prescribed by a physician;
- primarily and customarily used only for a medical purpose;
- appropriate for use in the home;
- designed for prolonged and repeated use; and
- not generally useful to a person who is not ill or injured.

Examples of Durable Medical Equipment include wheelchairs, hospital-type beds, walkers, traction equipment, ventilators and oxygen equipment.

Durable Medical Equipment does not include such items as air conditioners, bathroom equipment, dehumidifiers, whirlpool baths, exercise equipment and other equipment that has both non-medical and medical uses, even if deemed Medically Necessary.

Durable Medical Equipment that costs more than $250 requires Prior Authorization from the Plan Administrator.

Prosthetic Devices

Coverage is available for the purchase, fitting, necessary adjustments, repairs and replacement of prosthetic devices and supplies prescribed by a physician that replace:

- all or a portion of an absent body part (e.g., artificial limbs);
- the lens of an eye; or
- all or part of the function of a permanently inoperative or malfunctioning body part.

However, external prostheses will be replaced only when replacement is due to growth or pathological changes of the affected site, or due to wear and tear of the prosthetic that renders it unable to perform the functions for which it was designed.

Benefits are also available for prosthetic devices which are attached to or inserted into prosthetic shoes, and which replace a missing, inoperative, absent or malfunctioning body part.

Coverage is not available under this benefit for hearing aids, dentures or eyeglasses.

Prosthetic Devices that cost more than $250 require Prior Authorization from the Plan Administrator.

Orthotics

When ordered by a physician or a podiatrist, Benefits are provided for rigid or semi-rigid support devices that restrict or eliminate the motion of a weak or diseased body part. Examples include: splints, air casts and carpal tunnel devices. Benefits are only paid for corrective shoes that are attached to a brace and shoe inserts that are required to be custom made.

In cases of circulatory or neurological diseases involving the feet, such as arteriosclerosis or diabetic neuropathy, custom made shoes are covered if Medically Necessary.

Ostomy Supplies

Benefits are payable for Medically Necessary ostomy supplies which include; ostomy pouches, wafers, flanges, stomahesive paste and powder, and urinary catheters.

Vision Care Benefits

The following routine vision care services are payable under the plan:

- one vision examination, including a routine refraction, every 24 months; and
- one pair of lenses every 24 months, but only if a new or changed prescription makes it necessary to buy new lenses.

The plan will pay up to $100 every 24-month period for vision exams and lenses combined.

The Member must use an ophthalmologist, an optometrist or an optician for these services. If a Member visits an optometrist for reasons other than a routine vision exam, the optometrist's bill is paid under the regular medical Benefits, not the vision care benefit. Lenses to replace the lens of the eye are covered under the medical benefit.

The vision care benefit does not cover:

- sunglasses;
- frames;
- repair of lenses or frames;
- replacement lenses when no prescription change is necessary; or
- cosmetic extras, such as tinting or coating of lenses.

Dental Services Covered by the Medical Plan

Most dental procedures are covered under the Vermont State Employee Dental Assistance Program. The medical plan covers only the following dental services:

- diagnosis and treatment of a musculoskeletal disorder that is the result of accident, trauma, congenital or developmental defect, including temporomandibular joint syndrome. This care can be prescribed or administered by a physician or a dentist, but does require a referral from your Primary Care Provider;
- care for an accidental injury to the jaw, natural teeth, mouth or face while a Member of the plan; and
- oral surgery to correct a gross deformity resulting from major disease or from surgery performed under this coverage.

Limitations

Benefits are provided for oral surgery or care made necessary by an accident or injury for up to six months following the accident or injury and include mandibular orthopedic repositioning appliances if Medically Necessary. Appliances, services, supplies or procedures to change the height of teeth or otherwise correct an occlusion (e.g., braces) are not covered.

Hospitalization for Dental Services

If it is Medically Necessary for a Member to have certain dental work covered by the dental plan done in a Hospital (Outpatient or Inpatient), Hospital charges, and anesthesia charges are payable under this plan. Oral surgery fees, including fees for anesthesia administered by the dentist, are not covered under this plan.

Transplant Procedures and Benefits

Transplants are covered only with Prior Approval. Members must notify the Plan Administrator as soon as possible after learning they may need a transplant.

Regular Benefits

Transplants other than those listed below such as kidney and corneal transplants, will be covered as any other benefit under the general provisions of the plan.

Special Benefits

Special benefit are provided only for the following transplants:

- heart;
- heart/lung;
- lung;
- liver;
- pancreas; and
- bone marrow/stem cell (allogeneic or autologous)

For these transplants, Benefits are provided for transplant of an organ or bone marrow, including certain donor-covered expenses, if the plan covers the recipient. The plan also covers the following related transplant expenses:

- $20,000 for procurement of the organ;
- $10,000 in private duty nursing care; and
- $10,000 for transportation, meals and lodging (limited to $200 per day in lodging and meals).

Benefits are provided under this Special Transplant section for covered expenses that are directly related to the transplant procedures when they are incurred from five days before the procedure to 18 months after the procedure.

All requests are reviewed for Prior Approval based on:

- the patient's medical condition;
- the qualifications of the physician performing the transplant procedure, and
- the qualifications of the facility hosting the transplant procedure.

If your physician tells you that you may require a transplant, please call CIGNA Healthcare at 1-800-351-8513. They will make arrangements for a review of your condition and any travel or transportation you may need.

Lifetime Maximum for Special Transplants

Benefits for all transplant services and supplies are limited to $1,000,000 per transplant. This maximum is in addition to and separate from your overall lifetime benefit maximum for medical care.

All Transplants

Benefits for transplants are provided as follows:

- If the recipient of an organ and the donor are both covered under the plan, each person will receive Benefits under their own plan option. Services to donors will be charged against their plan.
- If a Member is the recipient and the donor is not covered under the plan, both the recipient and the donor will receive Benefits and they will all be charged to the recipient's Benefit maximum. Benefits will be paid to the donor only if Benefits remain under the plan after the recipient's Eligible Expenses are paid according to plan guidelines.
- No Benefits are available if a Member is a donor and the recipient is not covered under the plan.
- No Benefits are available for the price of an organ if the organ is sold rather than donated.

Mental Health and Substance Abuse Benefits

In-Network Services

Members have the choice of using a managed care Network Provider for services or a Provider outside the network. If a Network Provider is selected, Benefits are paid at 100% for Medically Necessary services. There are no predetermined limits except for General Lifetime Maximum Benefit.

Out-of-Network Benefits

Out-of-Network Provider services are subject to Deductibles, Coinsurance and limits. Deductible amounts incurred for out-of-network mental health and substance abuse care are applied to the annual out-of-network Deductible for all care. Coinsurance amounts, if any, for out-of-network mental health and substance abuse care are not applied toward the annual medical Coinsurance maximum.

Inpatient Services

All in-network and out-of-network Inpatient services, except emergency admissions, must be pre-approved by CIGNA Behavioral Care (CBH). Inpatient services that are not pre-approved may not be reimbursed. CBH must be notified of emergency admissions within 48 hours of the admission or as soon as reasonably possible.

Outpatient Services

No prior authorization is required for routine in-network or out-of-network Outpatient services.

Prior authorization is required for participation in intensive outpatient programs. These programs require a minimum attendance of 2 hours per day, 2 or more days per week.

Covered Services

Covered mental health and substance abuse care services include, but are not limited to, psychological or psychiatric treatment of the following conditions:

- alcohol and substance dependence and/or abuse;
- anxiety disorders/stress;
- adjustment disorders;
- depression and manic depressive conditions;
- eating disorders, and
- family and marital problems (in-network only).

Exclusions

Exclusions under the mental health and substance abuse portion of the plan include, but are not limited to, treatment of the below listed conditions:

- organic Mental Disorders. Changes in behavior induced by trauma to the brain or structural, chemical or metabolic changes in the brain. (Dementia resulting from early onset of Alzheimer's disease is an organic mental disorder. However, behavioral management of the early onset of Alzheimer's is covered under mental health Benefits when requested by a mental health professional. This would include medication management of psychotropic medication, early stage individual therapy to manage depression and anxiety symptoms, family education, and behavioral management and neuropsychological testing for the purpose of a rule-out diagnosis);
- mental retardation and autism, except for acute, brief interventions, and
- developmental and learning disabilities.

Schedule of Benefits

The Schedule of Benefits for Mental Health and Substance Abuse is on the next page.

SelectCare POS Mental Health / Substance Abuse Care

Program Feature	In-Network	Out-of-Network
Annual Deductible	None	$500 Individual, $1,000 Family (Combined with Medical) No maximum
INPATIENT CARE: Acute inpatient hospitalization, Mental Health or Substance Abuse Detoxification Partial hospitalization, Mental Health or Substance Abuse Residential treatment, Mental Health (Residential and Partial Hosp – counted as 2 partial days to 1 inpatient day)	100% Coverage (no deductible)	70% Coverage after deductible has been met. (Employee pays 30% after deductible)
Annual Limit	No predetermined limits	60 Days annual maximum Mental Health & Substance Abuse combined. (in-network benefits remain available even if all out-of-network days have been used)
Inpatient Substance Abuse Residential Treatment Facility	100% Coverage (no deductible)	In State: 70% Coverage after deductible (Employee pays 30% after deductible) Out of State: $200 per day maximum coverage for out of state residential treatment facility 56 Day Lifetime Maximum (in-network benefits remain available even if all out-of-network days have been used).

Continued on next page

Mental Health / Substance Abuse Care Continued

Program Feature	In-Network	Out-of-Network
OUTPATIENT CARE:		
Mental Health		
Individual and Group	100% Coverage (no deductible)	70% Coverage after deductible (Employee pays 30% after deductible)
Marital/Family Counseling	100% Coverage (no deductible)	Covered in-network only
Annual Limit – Mental Health	No predetermined limits	26 Visits annual maximum mental health (In-network benefits remain available even if all out-of-network visits have been used.)
Substance Abuse		
Individual and Group	100% Coverage (no deductible)	70% Coverage after deductible (Employee pays 30% after deductible.)
Annual Limit – Substance Abuse	No predetermined limits	60 Visits annual maximum
Lifetime Limit – Substance Abuse	No predetermined limits	120 Lifetime maximum visits *In-network benefits remain available even if all out-of-network visits have been used.*
Lifetime Limit	No predetermined limits	$2,000,000 Combined w/Medical See above for out-of-network lifetime limits for specific services.
Prior Authorization		
Inpatient Care	Prior authorization required for all Inpatient care.	
Outpatient Care	No prior authorization is required for routine Outpatient care.	
Medical Necessity	All coverage is subject to Medical Necessity.	
Emergency Admissions	For emergency admission, notification must be received within 48 hours of admission.	

Chapter 4: Prior Approval & Managed Benefits

Prior Approval

Procedures that Require Prior Approval

- **Hospital or Facility Admissions**
  ALL ADMISSIONS TO ANY TYPE OF FACILITY THAT ARE NON-EMERGENCY ADMISSIONS MUST RECEIVE PRIOR AUTHORIZATION. In case of an emergency admission or childbirth, a Member may not be able to contact the plan before being admitted. However, the plan must be notified within 48 hours of an emergency admission and within 24 hours of a maternity admission, or as soon as reasonably possible. The Member, a family member, the admitting physician or the Hospital may call the plan.

How to Request Prior Authorization

For medical, mental health or substance abuse services:

Either the Member or the Provider may request Prior Authorization. The telephone number is found on the Member ID card and most physician offices have the number. There are separate phone numbers for mental health and substance abuse services and other medical services. The caller should be prepared to provide the following information:

- the Member's name, address, phone number and member number;
- the Provider's name, address and phone number;
- the name and location of any Hospital or facility that may provide care;
- the reason for the healthcare services or supplies; and
- the proposed date for performing the services or providing the supplies.

Additional information may be requested as part of the Prior Authorization process if needed.

For Prescription Drugs:

Most prescribed medications will be dispensed without the need for authorization. However, a limited number of prescription drugs require Prior Authorization before being dispensed. Drugs requiring Prior Authorization at the time this summary was prepared are listed in the Prescription Drug Schedule of Benefits in Chapter Three of this summary. Other drugs may be added from time to time. (An updated list may be obtained from the Benefits Division website or by calling the Benefits Division.) If you are prescribed a drug that requires Prior Authorization, have your doctor or the pharmacist call the phone number on your pharmacy ID card before you fill the prescription. This will save you time at the pharmacy.

Prior Authorization Response Times

- **Non-Emergency Medical Services**
  When a Member or Provider requests a Prior Authorization for medical services, the plan will generally notify the requester of the determination within 15 days after receiving the request.

- **Emergency Medical Services**
  If the determination periods stated above would seriously jeopardize life, health, or the ability to regain maximum function, the Prior Authorization decision will be expedited.
- **Mental Health and Substance Abuse Services**
  If a Provider requests a Prior Authorization for Inpatient care, a decision will generally be provided within two business days of receiving the information necessary to make a decision. No prior authorization is required for routine Outpatient care.

Failure to Request Prior Authorization

Failure to obtain Prior Authorization may result in no Benefits being paid for the supplies or services obtained, even if such items are covered under the plan.

Continued Stay Review

When a Member is receiving medical services in a Hospital, the Plan Administrator may contact the Member's physician to:

- assure that continued stay is Medically Necessary;
- advise health care Providers of the various options and alternatives available under this plan;
- assist with discharge planning, and
- help coordinate care following release from the Hospital.

If an attending physician recommends that a Hospital stay exceed the number of days preauthorized by the plan, they must request the additional days at least 24 hours before the end of the approved length of stay. The plan will respond within 24 hours of receiving the request.

The following is important to note:

- not all services recommended or provided by a Provider may be considered Medically Necessary under the plan's definitions, and
- certification of Medical Necessity does not mean that plan Benefits will be payable. For example, the service may not be covered or the Member may have exceeded a Maximum Plan Benefit.

Retrospective Review

All claims for services or supplies that were required to be reviewed under the plan's Prior Authorization and Continued Stay provisions, which were not reviewed at the appropriate time, may be subject to retrospective review to determine if they were Medically Necessary. Services found to not be Medically Necessary will not be paid by the plan and will become the responsibility of the Provider or the Member. However, Members have the right to Appeal this decision as outlined in the Appeals section in Chapter 5.

Medical Case Management

How Medical Case Management Works

Case Management is conducted by medical professionals who work with a patient, family, caregivers, healthcare Providers, benefits personnel and the plan to coordinate the most appropriate and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex and/or high-technology services, or to help guide patients and their families through complicated medical treatment and multiple Providers. Case Management staff may also assist by comparing your plan Benefits to a Provider's suggested treatment, and suggesting an alternate, medically appropriate course of treatment if the proposed treatment is not covered. Case Management services are provided at the discretion of the Plan Administrator and may be requested by a Member or a Member's representative (e.g., Provider, Spouse or parent).

Working with the Case Manager

Case Managers work directly with Providers, Hospitals, and other facilities to review proposed treatment plans and to assist in coordinating services. Case Managers also contact patients and/or their families to assist in making plans for continued healthcare services. The Member, a family member, or a physician may call the Case Manager at any time to ask questions or make suggestions.

Chapter 5: Claims

Claim Submission and Payment of Benefits

Claim Submission

If you use a Participating Provider, they will submit a claim directly to the plan for payment. A Nonparticipating Provider may either require payment first or bill the plan. Claim forms may obtained from the Benefits Division, or online at www.vermontpersonnel.org/htm/library.cfm.

Payment of Benefits

The plan will make payments directly to Participating Providers and to the Member for services received from Nonparticipating Providers. However, the plan does reserve the right to pay Nonparticipating Providers directly.

Time Limit For Filing a Claim

All claims must be submitted to the plan within two years from the date of service. No Benefits will be paid for any claim not submitted within this two-year period.

When A Member Must Repay Plan Benefits

If the plan paid more than it should have because:

- some or all of the medical expenses were not payable by a Member; or
- a Member received payment from a source other than the plan which is legally liable for the payment of some or all of the incurred medical expenses; or
- a Member received any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party (**Note:** the plan maintains its full right to Subrogation regardless of what portion or amount of a settlement is specified for the medical expenses for which plan Benefits were paid); or
- the plan mistakenly paid Benefits to which a Member was not entitled under the terms and provisions of the plan,

then, the plan will be entitled to a refund from the employee and the Provider, equal to the difference between the amount of plan Benefits which were paid and the amount of plan Benefits that should have been paid.

If Benefits are paid incorrectly to the Member, the plan will require the Member to repay for any incorrect overpayment. If this happens, a written notice requesting a refund will be sent. If the plan pays your Provider incorrectly, the plan reserves the right to seek reimbursement from your Provider. In either case, the plan may reduce or withhold future Benefits to recover incorrect payments.

When a Claim is Denied

When a claim is denied, the Member and the Provider will be given written notice that includes all of the following information:

(1) the specific reason or reasons for the adverse determination;
(2) reference to specific plan information on which the determination is based;

(3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
(4) a description of the plan's review procedures and the time limits applicable; and
(5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

If a Member does not agree with a claim determination, the Member may Appeal the determination.

Release of Information

By Plan

The plan will comply with federal and state law regarding confidentiality. Any individually identifiable information collected by the plan will be treated as confidential information and will not be disclosed to anyone without a Member's written consent, except as:

- required to administer the plan or to process claims;
- required for quality audits (auditors will be required to be bound by confidentiality agreements);
- required by law or regulation or in response to a duly issued subpoena, or
- as reasonably required in the pursuit or defense of any claim action brought by or against the plan or any contracted Plan Administrator or insurer.

By Member

You may be requested to furnish information to verify eligibility for coverage to support the payment of a claim. Information that may be requested includes that related to, but not limited to:

- change of name;
- change of address;
- Medicare enrollment or disenrollment;
- existence of other medical coverage;
- marriage, divorce, dissolution of a civil union or Domestic Partnership, or death of any Member;
- status of a Covered Child including, but not limited to:
  - the child reaching the plan's limiting age;
  - the full-time school status of a Covered Dependent child over age 18; or
  - information required to make an initial and ongoing determination of the incapacitation status of a child.

A Student Certification Form must be submitted annually to verify a Covered Child's status as a full-time student if that child is 19 years of age or older. The Plan Administrator will send a Student Certification Form to the Member each year. **Failure to return the Student Certification Form will result in a Covered Child's coverage being canceled.**

To extend coverage for an Incapacitated Child beyond the age of 18, proof of the incapacitation must be submitted at least 60 days before coverage would otherwise end, and annually thereafter.

If a Covered Dependent becomes ineligible for coverage, an Enrollment/ Change Application must be filed with the Employee Benefits Division. Otherwise, an employee may continue to pay for that dependent even though the coverage has ended. No refunds are allowed. This information must be provided for enrollment purposes even if the change will not affect the type of coverage (i.e., two person or family).

Failure to provide any information requested by the plan may result in Benefits not being provided by the plan.

Appeal Process

Medical Claims and Mental Health/ Substance Abuse Claims

If a Member does not agree with a plan decision to deny coverage for a claim, or does not agree with how a claim was paid, the Member should call the Member Services phone number found on the ID card or inside the front cover of this summary. Most issues can be clarified by phone. If the Member is not satisfied with the response regarding a coverage decision, the Appeals process may be started.

The Member starts the Appeals process by calling the Appeals phone number listed inside the front cover of this summary to file a formal Appeal. The Member may also send a written Appeal to the address provided. Whether the Member files an Appeal by speaking to a plan representative or by writing to the plan, the Member should explain why the denial or payment should be reconsidered. The Member may want to provide facts that support this opinion and include any pertinent documents. The Member must submit the Appeal within 180 days of receipt of an eligibility determination, a denial of services or a payment decision. This Appeal is known as a level one Appeal.

Level One Appeal Process

The Appeal will be reviewed and the decision made by a representative not involved in the initial decision and who does not report to the individual who made the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a healthcare professional. For level one Appeals, a written response with a decision will be provided in writing within fifteen (15) calendar days after receipt of an Appeal of a pre-service or concurrent coverage determination, and within thirty (30) calendar days after receipt of an Appeal of a post-service coverage determination.

The Member may request an urgent consideration of the Appeal if:

(a) the time frames under this process would seriously jeopardize life, health or ability to regain maximum functionality, or, in the opinion of the treating physician, would cause severe pain which cannot be managed without the requested services; or

(b) the Appeal involves non-authorization of an admission or continuing Inpatient Hospital stay. The Plan Administrator's physician reviewer, in consultation with the treating physician, will decide if an urgent Appeal is necessary. When an Appeal is urgent, the Plan Administrator will respond orally with a decision within seventy-two (72) hours and will follow up with a written decision.

If the Member is dissatisfied with the level one Appeal decision, the member may request a second review within 90 days of receipt of the level one decision.

Level Two Appeal Process

To initiate a level two Appeal, follow the same process required for a level one Appeal. Most requests for a second review will be conducted by an Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision or who is a subordinate of anyone involved in the prior decision may not be on the second level Appeals Committee. For Appeals involving Medical Necessity or clinical appropriateness, the committee will consult with at least one physician in the same or similar specialty as the care under consideration, as determined by the Plan Administrator's physician reviewer. The Member or Member's representative may present their situation to the Committee in person or by conference call. The plan will provide at least two weeks notice of the date the Member's Appeal will be heard. Level two Appeal requests will be acknowledged in writing. For pre-service and concurrent care coverage determinations, the Appeals Committee review will be completed within fifteen (15) calendar days of receipt of a request. For post-service claims, the Committee review will be completed within thirty (30) calendar days of the request. Members will be notified in writing of the Appeal Committee's decision within five (5) business days after the Committee's meeting.

The Member may request an urgent Appeal process if:

(a) the time frames under this process would seriously jeopardize life, health or ability to regain maximum functionality, or, in the opinion of the treating physician, would cause severe pain which cannot be managed without the requested services; or

(b) the Appeal involves non-authorization of an admission or continuing inpatient Hospital stay. The Plan Administrator's physician reviewer, in consultation with the treating physician, will decide if an urgent Appeal is necessary. When an Appeal is urgent, the Plan Administrator will respond orally with a decision within seventy-two (72) hours and follow up with a written determination.

Notice of Benefit Determination on Appeal

Every notice of a determination on Appeal will be provided in writing or electronically and, if it is an adverse determination, will include:

(1) the specific reason or reasons for the adverse determination;
(2) reference to the specific plan provisions on which the determination is based;
(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; and
(4) notice that upon request and free of charge, a Member may receive a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding his Appeal, and an explanation of the scientific or clinical judgment for a determina-tion that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

Relevant Information

Relevant information is any document, record, or other information which:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(c) demonstrates compliance with the administrative processes and safeguards required by federal law [29 CFR Part 2560.503-1 (b)(5)] in making the benefit determination; or

(d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Prescription Drug Benefit Appeals

If a Member does not agree with a decision of the plan's Pharmacy Benefit Manager (PBM) regarding a Prior Authorization request, the dispensing of a brand drug, the payment of a claim or any other drug benefit determination, the Member may Appeal the decision within 180 days of the decision, by calling the phone number on the drug plan ID card or by writing to the address provided on the inside front cover of this summary.

The pharmacy Benefit has a two-level Appeal process. The first level of Appeal is handled by the PBM. If the Member receives a determination on a Prior Authorization request with which the Member does not agree and then submits an Appeal, a decision will be rendered within 72 hours if all information necessary to make a decision has been provided to the PBM. If a Member pays for a prescription (either in whole or in part) and Appeals the PBM's payment decision, the Member will usually receive a determination within 30 days.

If a Member does not agree with the PBM's decision regarding a level one Appeal, the Member may initiate a level two Appeal. Detailed information regarding the second level Appeal process is provided by the PBM upon delivery of the first level Appeal decision. Level two Appeals are performed by an independent review organization.

As with the first level Appeal process, decisions regarding Urgent Care Appeals are rendered within 72 hours of receipt of the information necessary to render a decision. Decisions regarding non-urgent Prior Authorization requests are rendered within 15 days of receipt of necessary information. Decisions regarding payments made by the plan are usually rendered within 30 days of receipt of the Appeal and the information necessary to render a decision.

If information necessary to render a decision is not provided, a decision will be made with the information available to the independent review organization.

When pursuing an authorization or payment denial, a Member is entitled to receive any guidelines, rules or protocols relied upon in making the decision, and all documents, records and other information relevant to the determination, regardless of whether this information was relied upon in making the determination.

State of Vermont External Appeal Process

In addition to the Appeals processes outlined above for medical care and prescription drugs, Members have additional Appeal rights available under Vermont state law (Regulation H-99-1). A Member can request that an independent panel review an Appeal after completing the plan's internal Appeals processes. If a Member submits an Appeal, the Member should keep a detailed record of all conversations regarding the Appeal and a copy of the records submitted.

For further information, Members may review Regulation H-99-1 or Bulletin 104 of the State of Vermont Department of Banking, Insurance, Securities and Healthcare Administration (BISHCA) or contact BISHCA directly.

Chapter 6: Exclusions

Exclusions

The following medical conditions, services, supplies or expenses are not covered by the plan. The Plan Administrator and other plan fiduciaries and individuals to whom responsibility for the administration of the plan has been delegated, have authority to determine the applicability of these exclusions and other terms of the plan and to determine eligibility and entitlement to plan Benefits. Decisions by these individuals may be appealed by Members. Any Member who is uncertain as to whether or not a medical condition, service, supply or expense is covered by the plan should contact the plan.

Acupuncture. Acupuncture is not covered unless performed by a licensed physician.

Aids. Artificial aids including, but not limited to, corrective orthopedic shoes not attached to a brace, arch supports, commercially available shoe inserts, elastic stockings, dentures and wigs, except as specified elsewhere in this summary.

Ancillary Services. Non-medical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.

Blood. The plan does not pay for whole blood, blood plasma, packed blood cells or other blood products if these products are available to the providing facility without cost. However, Benefits are provided for the administration, processing and storage of blood and its derivatives, including autologous blood donations.

Charges More Than Two Years Old. Charges for covered services incurred more than two years prior to the date a claim is received from a Member or a Nonparticipating Provider.

Chronic Conditions. Therapy to improve general physical condition if not Medically Necessary, including, but not limited to, routine, long-term chiropractic care and other rehabilitative services. Therapy is also not covered when it does not: help restore or maintain a Member's health, prevent deterioration of a Member's condition, or, does not prevent the reasonably likely onset of a health problem. Benefits are not payable for conditions related to learning disabilities or developmental delays.

Cognitive Retraining.

Consumable Medical Supplies. Consumable, non-prescription medical supplies, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as provided under "Covered Services and Supplies."

Convenience, personal service and comfort items and environmental modifications. Includes, but is not limited to, air conditioners, humidifiers, physical fitness equipment, stair glides, elevators, lifts (including those with track systems which mount to walls and ceilings), "barrier free" or other home modifications, health or fitness club fees, chairs with built-in lift mechanisms, shaped pillows, etc., even if prescribed by a physician.

Cosmetic surgery/therapy. Cosmetic surgery or Cosmetic therapy to improve or preserve physical appearance is not covered. However, the plan will pay for reconstructive surgery when performed to correct a condition resulting from an accident, injury or illness incurred while covered under the plan. This includes reconstructive surgery following a mastectomy to reconstruct a breast on which surgery has occurred or to reconstruct a breast on which surgery has not occurred to produce symmetry. The plan will also pay for reconstructive surgery required as a result of congenital disease or anomaly in a child under age 19.

Custodial Services, Education or Training. Charges in connection with Custodial Care (regardless of where provided), including, but not limited to, adult day care, child day care, services of a homemaker, or personal care, except where Custodial Care is provided as part of a hospice program), rest homes, convalescent homes, homes for the aged, domiciliary care, institutional care for the physically or mentally handicapped, education evaluation and education programs, therapy or training, supplies and equipment (including computers, software, books, aides, etc.) even if required because of injury, illness or disability (with exception of diabetes education), including programs for the activities of daily living, instruction in scholastic skills such as reading and writing, or treatment for learning disabilities. However, Outpatient self-management training and education for the treatment of diabetes, including nutritional therapy, is covered.

Customized Equipment. Expenses for custom services, supplies, appliances or Durable Medical Equipment (DME) when standard, non-customized services, supplies, appliances or DME are available and would provide a medically appropriate outcome.

Dental. Treatment of the teeth or peridontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (b) charges made by a Hospital for bed and board or necessary services and supplies; or (c) charges made by a free-standing surgical facility or Outpatient department of a Hospital in connection with surgery. For the purposes of this coverage by the plan, an accident does not include any injury caused by biting or chewing while eating. Also excluded from coverage are expenses for dental prosthetics, dental services, or dental supplies of any kind, even if they are necessary because of symptoms, illnesses or injury affecting another part of the body; expenses for appliances (other than a mandibular orthopedic repositioning appliance) and services and procedures to change the height of teeth or otherwise restore occlusion.

Drugs. Charges for prescription drugs excluded from the plan or for drugs that do not require a prescription by federal law. Drug Exclusions are detailed in the Pharmacy Schedule of Benefits in Chapter 3.

Duplicate Corrective Appliances. Including orthotic devices, prosthetic appliances, and Durable Medical Equipment.

Excess Charges. To the extent charges are more than Reasonable and Customary Charges.

Expenses for Which a Third Party is Responsible. Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See Third Party Liability in Chapter 7 of this summary for an explanation of the circumstances under which the plan will advance the payment of Benefits until it is determined that the third party is required to pay for those services or supplies.

Expenses Incurred Before or After Coverage. Expenses for services rendered or supplies provided: (a) before becoming covered under the Medical plan; or (b) after the date a Member's coverage ends, except under those conditions described in Chapter 2 of this summary describing Termination of Coverage.

Experimental, Investigational or Unproven Treatment Methods. Experimental, investigational or unproven treatment methods, procedures, drugs or supplies are those which are not generally accepted by informed healthcare Providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, and/or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed. However, care received in approved cancer trials as outlined in Chapter 9 is covered.

Eye Care, Select Services. Eye exercises, visual training and surgical treatment for the correction of a refractive error, including radial keratotomy and lasik surgery, when eyeglasses or contact lenses may be worn to provide corrected vision.

Failure To Meet Requirements of Primary Plan. Medical treatment when payment is denied by any Member's Primary plan because treatment was received from a Nonparticipating Provider.

Foreign Care. Charges for medical care obtained while outside the United States or Canada, including Hospital care, medical supplies, prescription drugs and Provider services are excluded, when the primary purpose of being outside the United States or Canada was to obtain medical care. Expenses for care incurred outside of the United States or Canada in a country in which a Member maintains a residence are covered at out-of-network Benefit levels. Care obtained outside the United States or Canada while traveling on business or for pleasure is also covered at the out-of-network Benefit levels.

Gender Change. Transsexual surgery, including medical or psychological counseling, studies and hormonal therapy or any other services in preparation for, or subsequent to, any such surgery, unless procedure began before July 1, 1992. Also excluded are any complications resulting

from transsexual procedures initiated after July 1, 1992.

Genetic Services. Genetic testing that is not Medically Necessary is excluded from coverage. The following criteria will be used to help assess Medical Necessity:

- the Member displays clinical features, or the Member or his/her offspring would be at direct risk of inheriting the mutation in question (presymptomatic); and
- after history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain; and
- the result of the test will directly impact the treatment being delivered to the Member.

Government Facilities. Charges made by a Hospital, facility or clinic owned or operated by, or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected sickness or injury.

Government Provided Services. Services or supplies paid, or eligible for payment, directly or indirectly, by a local, state or federal government agency, except as otherwise provided by law. This exclusion applies whether or not a Member asserts the right to obtain this coverage or payment for these services.

Hair Replacement Procedures, Medications and Devices. Expenses for hair transplantation and other procedures to replace lost hair or to promote the growth of hair; for the use of Propecia, or other prescription drugs or medicines used to promote the growth of hair, or for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces. The plan will provide Benefits for a single wig, toupee or hairpiece if it is required to replace hair lost as a result of chemotherapy or alopecia.

Hearing Aids. The purchase, fitting, adjusting, servicing or repair of hearing aid devices, including but not limited to hearing aids and examinations for the purpose of prescription of such devices.

Home Health Care.

- Home health care services provided by someone who is related by blood, marriage, civil union or Domestic Partnership, or who lives in the patient's home, or when the patient is not under the continuing care of a physician.
- Expenses for a homemaker, Custodial Care, childcare, adult care or personal care attendant except as provided under the plan's hospice coverage.
- Any service that a family member who is not a licensed healthcare professional is typically trained to perform even if the service is Medically Necessary.

Illegal Occupation or Act. The plan shall not be liable for any loss to which a contributing cause was a Member's commission of, or attempt to commit a felony, or to which a contributing cause was the Member's being engaged in an sillegal occupation.

Illegal Services. To the extent that the service rendered is unlawful where the person resides when the expenses are incurred.

Infertility Donor Charges. Infertility donor charges and services, whether or not the donor is covered by the plan.

Injuries Due to War or Military Service. Illnesses or injuries, which are:

- a result of an act of war, declared or undeclared, for which treatment is provided by the government, or
- sustained during military service and the Department of Defense or the Veterans Administration has the responsibility to provide the service or care and the services of these government entities are reasonable available to the Member.

Inpatient Charges If An Inpatient On The Effective Date of Coverage. If a Member is an Inpatient on the date coverage becomes effective, coverage will be provided by the plan if the plan or the plan's agent is the authorized utilization management authority, unless the Member has Benefits under another plan that are extended. If a Member has Benefits under another plan when coverage under this plan becomes effective, this plan shall be responsible upon discharge from the facility or when the Benefits from the other plan expire, whichever comes first.

Job Related Injuries/Illnesses/Workers' Compensation. Treatment of any job-related illness or injury for which a covered person has received, or is entitled to receive a benefit under workers' compensation, whether by settlement or by adjudication. All injuries or illnesses that may be covered under workers' compensation must be submitted to the workers' compensation plan before they will be considered for reimbursement under this plan.

Limitations and Maximums. Charges for services or supplies in excess of limitations or maximums set forth in this summary.

Massage Therapy. Massage therapy not performed by a licensed physician, physical therapist or occupational therapist.

Mental Retardation or Autism. Care for mental retardation or autism, except for acute, brief interventions when other diagnoses are present.

Midwife Services. Services rendered by midwives who are not certified nurse midwives and licensed by the state in which they practice.

Miscellaneous. Acupressure, rolfing, reiki, aromatherapy, naprapathy, stone therapy, hypnotherapy, naturopathy, homeopathy, self-help training and other therapies not specifically listed as covered.

No Cost Services. Charges for services or supplies for which a Member:

- is not obligated to pay;
- is not billed;
- would not have been billed except that they were covered under this policy, or
- would not legally have to pay if there was no coverage.

Nonmedical Charges. Charges from Providers for failure to keep a scheduled visit, completion of a claim form, photocopying, or discussing care with family members, caregivers, a health plan or health plan affiliate including utilization management, disease management or case management personnel.

Not Medically Necessary. Charges for supplies, care, treatment or surgery which are not considered Medically Necessary for the care and treatment of an injury or sickness or that are not provided in accordance with accepted professional medical standards in the United States, as determined by the plan. This includes counseling, immunizations, or vaccinations related to travel outside the United States.

Nutritional Counseling, Formula and Medical Food. Excluded are foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided during hospitalization, and expenses for nutritional counseling in the absence of an illness (e.g., diabetes), as determined by the Plan Administrator. High calorie and/or high protein food supplements or other food or nutritional supplements are covered in conjunction with Medically Necessary treatment of inherited metabolic disease, severe food allergies, anorexia, bulimia or acute starvation.

Ordered Services. Services for reports, evaluations, physical examinations or hospitalization ordered for employment, insurance, government licenses, forensic evaluations and custodial evaluations or court orders (unless Medically Necessary, ordered by a Provider and covered by this plan).

Phone Calls. Telephone consultations between Providers and Members except within the first six weeks of discharge for childbirth if the child was discharged less than 24 hours from birth.

Prior Authorization Not Obtained. To the extent of the Exclusions imposed by any requirement shown in the Schedule of Benefits or in this summary.

Private Room. Accommodations for private room unless Medically Necessary.

Prostheses, External, Replacement. Replacement of an external prosthesis due to loss, theft or destruction is not covered. However, external prostheses will be replaced when replacement is due to growth or pathological changes of the affected site, or due to wear and tear of the prosthetic that renders it unable to perform the functions for which it was designed.

Relatives and Members of the Member's Household. Charges made by any covered Provider who is a member of the Member's household or family (includes grandparents, parents, Spouse, Civil Union Partner, Domestic Partner, siblings, in-laws and children, by birth or marriage) are excluded.

Routine Foot Care. The following routine foot care is not covered:

- palliative or Cosmetic foot care;
- treatment for bunion, metatarsalgia (pain and tenderness in the metatarsal region), flat feet, fallen arches, weak feet, chronic foot strain or subluxation of the feet other than an open cutting operation;
- orthotic shoe inserts, (unless required to be custom made);
- cutting or removal of corns, calluses and/or trimming of nails;
- application of skin creams; and
- other hygienic and preventative maintenance care.

In cases of circulatory or neurological disease involving the feet, such as arteriosclerosis or diabetic neuropathy, routine foot care is covered, including the treatment or removal of corns, calluses, bunions and toenails.

Speech Therapy, Select Services. Speech therapy services which:

- are used to improve speech skills that have not fully developed;
- can be considered custodial or educational;
- are intended to maintain speech communication, or
- are provided as part of chronic pain control,

are not covered. Any speech therapy which is not restorative in nature or which is not provided by a licensed speech therapist or certified speech therapist where licensure is not required, will not be covered.

Sterilization Reversal. Charges for or in connection with procedures to reverse sterilization.

Support Therapies. Including, but not limited to, pastoral counseling (excluding hospice, in which case pastoral counseling is covered); assertiveness training; dream therapy; music or art therapy; recreational therapy and smoking cessation therapy.

Transplantation (Organ and Tissue). Expenses for human organ and/or tissue transplants that are experimental and/or investigational, including, but not limited to, donor screening; acquisition and selection; organ or tissue removal; transportation; transplantation; post operative services and drugs or medicines, and all complications thereof.

Transportation, Non-Ambulance. Expenses for and related to travel or transportation (including lodging, meals and related expenses) of a Provider, Member (non-ambulance) or family member of a Member, even if prescribed by a physician (except as specifically stated under the Organ Transplant coverage).

Weight Management.

- **Obesity.** Medical, surgical and other services intended primarily for the treatment or control of obesity which are not Medically Necessary, including diet supplements; appetite suppressants; prescription drugs; diet centers; weight loss programs; dietary instructions; health clubs; exercise programs; gymnasiums; physical fitness programs and weight reduction procedures designed to restrict the ability to assimilate food such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass are not covered. Complications attributable to any such procedures are also not covered.
- **Underweight.** Expenses for medical or surgical treatment of severe underweight (more than 25% under normal body weight), including but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements are not covered, except in conjunction with Medically Necessary treatment of inherited metabolic disease, severe food allergies, anorexia, bulimia or acute starvation.

Chapter 7: Other Party Liability

Coordination of Benefits

This Chapter applies when the Member is entitled to Benefits under two separate Health plans. There are several circumstances that may result in a Member being reimbursed for medical expenses not only from this plan, but also from some other source(s). This can occur if a Member is also covered by:

- another group healthcare plan; or
- Medicare or some other government program, such as Medicaid, CHAMPUS/ TRICARE, or any coverage provided by a federal, state or local government or agency; or
- workers' compensation.

Duplicate recovery of medical expenses can also occur if a third party is financially responsible for medical expenses because that third party caused the injury or illness giving rise to those expenses by a negligent or intentionally wrongful act.

Coordination of Benefits (COB) is a set of rules for the coordination of payments between plans. These rules identify the plan that will pay its Benefits first, called the primary plan. The other plan, called the secondary plan, may then pay additional Benefits. In no event will the combined Benefits of the primary and secondary plans (or any other group plans) exceed 100% of the medical expenses incurred. The State of Vermont's employee group health plan will only coordinate Benefits up to its own plan limits.

Which Plan Pays First: Order of Benefit Determination Rules

When two payers coordinate Benefits, one is considered the "primary payer" and one is the "secondary payer". The primary payer processes the claim first and makes payment. Next, the secondary payer processes the claim and may make an additional payment. This plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. The plan determines who is primary as follows:

- The payer covering an individual as an employee is primary to the payer who covers them as a dependent.
- If a child is covered under both parents plans, we use the NAIC "Birthday rule", which makes the coverage of the parent whose birthday is earlier in the calendar year (without regard to the year of birth) the primary payer.
- If the two rules above do not apply, the coverage with the earliest effective date is the primary payer and the other is secondary.

If two plans cover a dependent child of divorced or separated parents, in most cases a court will often decree that one parent be responsible for the health insurance of the child. In that case, the plan of the parent who has that responsibility is primary. If there is no such decree, Benefits will be determined in the following order:

- The plan of the custodial parent pays first.
- The plan of the Spouse or Partner of the custodial parent pays second.
- The plan of the non-custodial parent pays third.
- The plan of the Spouse or Partner of the non-custodial parent pays last.

If a court decrees that the parents will share custody of the child, without stating that one parent is responsible for healthcare expenses for the child, the "Birthday Rule" as described above will be used.

Medicaid

If a Member is covered by both this plan and Medicaid, this plan is primary and Medicaid is secondary.

CHAMPUS/TRICARE

If a Member is covered by both this plan and CHAMPUS/TRICARE, this plan is primary and CHAMPUS/TRICARE is secondary.

Veterans Affairs Facility Services

If a Member receives services in a U.S. Department of Veterans Affairs Hospital or facility for military service-related illness or injury, Benefits will not be paid under this plan.

Motor Vehicle Coverage

If a Member is covered for medical Benefits under any motor vehicle no-fault coverage required by law (includes Personal Injury Protection coverage), the motor vehicle no-fault coverage is primary and this plan is secondary. If a covered individual is covered for medical Benefits under a medical payments rider of a motor vehicle insurance policy, the motor vehicle coverage is primary.

Workers' Compensation

This plan does not provide Benefits if the medical expenses are covered by workers' compensation or occupational disease law.

Reimbursement and/or Subrogation Agreement

If the plan makes payments pending a determination of the legal liability of a person causing you injury, we will be subrogated to your rights of recovery from any person or organization that caused or contributed to your injuries or illness or paid as a result of them. This means:

- If a Member receives medical treatment for illness or injuries caused by another party, and the plan pays Benefits for any part of that treatment, the Member shall pay the plan all amounts recovered by suit, settlement or otherwise from any third party, its insurer or your insurer, to the extent of the Benefits paid by the plan. The plan reserves the right to bring a lawsuit in the Member's name against any responsible party to recover Benefits the plan has paid.

- The Member shall take such action, furnish the plan with information and assistance, and sign and deliver a Reimbursement and/or Subrogation Agreement as the plan may require to enforce our rights, and the Member shall take no action prejudicing our rights and interests under the plan.
- If the Member refuses to pay the plan or provide necessary information, the plan may take legal action to recover amounts paid. In the event it is necessary for the plan to take such action, the Member will be responsible for attorney's fees and expenses incurred by the plan in collecting the amount owed by the Member. Future Benefits may be reduced or withheld to recover monies owed to the plan.
- The Member agrees not to settle the claim without first notifying the plan. The plan reserves the right to compromise the amount of its claim if, in its opinion, it is appropriate to do so. The plan shall have a lien on the recovery from the person or organization causing you injury or illness for which the plan has paid Benefits.
- The plan will have no obligation to share the costs of, or pay any portion of, the Member's attorney's fees in obtaining any recovery against a person causing you injury.

Chapter 8: General Plan Provisions

Parties Responsible for Benefit Payment

The State of Vermont is liable for payment of medical and pharmacy Benefits according to provisions of this plan. The Plan Administrators for these Benefits do not insure or otherwise guarantee Benefits. The State of Vermont purchases stop-loss coverage to reimburse the plan for certain losses in excess of amounts specified in the stop-loss policy.

Mental health and substance abuse coverage is provided via an insurance policy. The insurer from whom the State of Vermont purchases mental health and substance abuse care coverage is responsible to pay plan Benefits as specified in this summary.

Parties Responsible for Administration of the Plan

The Employee Benefits Division, Department of Personnel, State of Vermont, is responsible for determining eligibility for the plan and providing eligibility information to the parties who administer the Benefits of the plan. The following parties are assigned Plan Administrator status for determining availability of Benefits under the plan for Members.

CIGNA HealthCare

Medical

CIGNA Behavioral Health

Managed Mental Health and Substance Abuse

Express Scripts, Inc.

Managed Pharmacy Benefits (including level one Appeal)

MCMC llc.

Second level pharmacy benefit Appeals

Plan Terms, Amendments, Associated Documents and Termination

The State of Vermont intends that the terms of this plan described in this summary, including those terms relating to coverage and Benefits, are legally enforceable, and that this plan is maintained for the exclusive benefit of participants, as defined by law.

Every effort has been made to make the information contained in the summary reflect the information contained in the Plan Document – the document which contains the details of the plan. If any information in this summary is in conflict with the provisions of the Plan Document or the contracts established with administrators and insurers to provide Benefits, or if any provision is not covered or only partially covered in this summary, the terms of the Plan Document and the contracts will govern in all cases.

The State of Vermont, reserves the right, subject to labor negotiation, to terminate, discontinue, alter, modify, or change this plan or any provision of this plan. Although it is the intention of the State of Vermont to continue to maintain this plan, in no manner should this plan be interpreted as providing permanent or irrevocable Benefits or type or level of Benefits. The plan or this summary or

any payments to you under the terms of the plan do not imply a contract of employment and do not give you the right to be retained as an employee. All amendments to the Plan Document shall be made in writing.

In the event of any dispute over eligibility for coverage or availability of Benefits, the following associated documents may provide more specific information:

- contract with CIGNA HealthCare for administration of medical Benefits;
- contract with Express Scripts, Inc. and its associated documents for managed pharmacy benefit administration;
- contract with MCMC llc. for second level managed pharmacy Benefit Appeals;
- contract with CIGNA Behavioral Health for managed Mental Health and Substance Abuse insurance coverage;
- contract with CIGNA HealthCare for stoploss coverage;
- labor agreements between the State of Vermont and the Vermont State Employees' Association, Inc.

Chapter 9: Definitions

Acute Care. Care that is intended to produce measurable improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time.

Acute Condition. An illness or injury, marked by a sudden onset or abrupt change of health status, that requires prompt medical attention. Care for an Acute Condition (Acute Care) may include hospitalization of limited duration.

Allowed Amount. The amount the Plan Administrator determines is Reasonable and Customary for services or supplies.

Ambulance. A specially designed and equipped vehicle, including a helicopter or airplane, for the emergency transportation of the sick and injured.

Ambulatory Surgical Care Facility. A facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures on an Outpatient basis and which fully meets one of the following two tests:

- is licensed as an Ambulatory Surgical Center under the laws of the jurisdiction in which it is located; or
- where licensing is not required, it is accredited by an accrediting body recognized by the Center for Medicare and Medicaid Services.

Annual Open Enrollment. The period specified by the Department of Personnel via the labor agreement, or as otherwise mutually agreed upon by the Vermont State Employee Association, Inc. and the Department of Personnel, during which employees may elect coverage, change plans, and add Eligible Dependents to the plan.

Appeal. An oral or written request made by or on behalf of a Member to the Plan Administrator which explicitly seeks reconsideration of a plan decision regarding participation in the plan or denial of reimbursement for, or coverage of, a service or supply the plan determined was not Medically Necessary, was not a covered service or supply, or was not an Eligible Medical Expense.

Approved Cancer Clinical Trial. An organized, systematic, scientific study of therapies, tests, or other clinical interventions for purposes of treatment, palliation, or prevention of cancer in human beings. The trial must seek to answer a credible and specific medical or scientific question for the purpose of advancing cancer care and:

- be conducted under the auspices of the Vermont Cancer Center at Fletcher Allen Healthcare, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center and a Vermont Hospital or its affiliated, qualified Vermont cancer care Providers;
- be conducted by a facility and personnel capable of conducting such a trial by virtue of experience, training and volume of patients treated to maintain expertise;

- enroll only those patients for whom there is no clearly superior, non-investigational treatment alternative to the cancer clinical trial and the available clinical or preclinical data provide a reasonable expectation that the treatment obtained in the cancer clinical trial will be at least as effective as the non-investigational alternative;
- be conducted only after obtaining fully informed, written consent from the patient or the patient's legally authorized representative in a manner that is consistent with current legal and ethical standards and requirements; and
- be conducted under the auspices of a peer-reviewed protocol that has been approved by one of the following entities:
  - one of the National Institutes of Health (NIH);
  - an NIH-affiliated cooperative group that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group;
  - the FDA in the form of an investigational new drug application or exemption; or
  - the federal departments of Veterans Affairs or Defense.

Benefit. The amount payable for a claim, based on Reasonable and Customary charges, after calculation of all Deductibles, Coinsurance, and Copayments, and after determination of the plan's Exclusions, limitations and maximums.

Benefits Division. The Employee Benefits and Wellness Division of the Department of Personnel, State of Vermont.

Birthing Center. A health facility that provides a home-like setting under a controlled environment for the purpose of childbirth. It must be staffed, equipped and operated to provide: (a) prenatal care; (b) delivery; (c) postpartum and (d) newborn care for 24 hours after childbirth. It must be licensed or approved by the authorized agencies of the jurisdiction in which it is located or it must be listed with the National Association of Childbearing Centers.

Case Management. A process in which healthcare professionals work with the patient, family, caregivers, and Providers to coordinate a timely and cost-effective treatment program. Case Management services are usually provided when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through the healthcare system.

Certificate of Creditable Coverage. A certificate provided upon termination from the plan that documents the period of coverage under the plan as required by the Health Insurance Portability and Accountability Act of 1996. This certificate may reduce Waiting Periods a plan may impose on a former Member.

Chronic Care. Treatment of an illness, injury or condition that is:

- not necessarily directed toward alleviation or prevention of an Acute Condition; and
- of long duration without any reasonably predictable date of termination.

Chronic conditions may be marked by recurrences of conditions requiring Acute Care on a periodic basis.

Civil Union Partner. A person of the same sex as the employee who is legally joined in civil union to the employee.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986). A federal act which grants employees, their dependents and certain others the right to continue receiving coverage under an employer's health plan(s) at a rate no higher than 102% of the group rate.

Coinsurance. The percentage of the Eligible Expense Members must pay after meeting their Deductible.

Copayment/Copay. A Cost Share which is typically a set dollar amount.

Cosmetic. Primarily intended to improve appearance.

Cost Share. The portion of an Eligible Expense for which Members are responsible.

Covered Child(ren). An unmarried dependent child who is enrolled in the plan.

Covered Dependent. An Eligible Dependent who is enrolled in the plan.

Covered Employee. An Eligible Employee, as described in Section II of this summary, who is enrolled in the plan.

Custodial Care. Primarily for maintenance or designed to help in a person's daily living activities. Custodial Care is not primarily provided for its curative value. Custodial Care includes:

- help in walking, bathing, dressing and feeding; or
- preparation of special diets; or
- supervision over administration of medications; or
- care not requiring skilled nursing services.

Date of Hire. The first completed full day of work as an employee, appointed official or elected official for a Special Group or the State of Vermont.

Deductible. The amount Members must pay toward the cost of services each calendar year before the plan pays any Benefits. Members may have a separate Deductible for services received from Nonparticipating or Out-of-Network Providers than from Participating or In-Network Providers.

Dependent Eligibility Date. The date a dependent becomes or became an Eligible Dependent.

Domestic Partner. A person of the same or opposite sex as the employee who meets the following criteria:

- the persons are each other's sole Domestic Partner and have been in an exclusive and enduring relationship sharing a residence for not less than six consecutive months prior to the submission of an application for coverage;
- the persons are 18 years or older;
- neither person is married to anyone;
- the parties are not related by blood closer than would bar marriage under Vermont state law;

- the persons are competent to enter into a legally binding contract; and
- the persons have agreed between themselves to be responsible for each other's welfare.

Persons who live together for economic reasons but have not made a commitment to an exclusive enduring Domestic Partnership as described above shall not be considered to be Domestic Partners.

Durable Medical Equipment. Equipment that: (1) can withstand repeated use; (2) is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; (3) is not disposable or non-durable; and (4) is prescribed by a physician. Durable Medical Equipment includes, but is not limited to, wheelchairs, hospital-type beds, walkers, traction equipment, ventilators and oxygen equipment.

Elective Surgery. Any surgical procedure that is not performed under emergency circumstances.

Eligible Dependent. An employee's:

- legally married Spouse from whom the employee is not legally separated;
- Partner through civil union;
- Domestic Partner (Only Domestic Partners of active state employees are Eligible Dependents. State retirees and members of Special Groups may not enroll a Domestic Partner into the plan);
- unmarried dependent children under age 19 not on active duty in the uniformed services of any country;
- unmarried dependent children from age 19 to their 23rd birthday who are enrolled as full-time students at an accredited school where full time student is as defined by the accredited school;
- Incapacitated Children; and/or
- newborn children are covered automatically for 60 days following birth. However, newborn children of dependent children are not Eligible Dependents and are only covered for 31 days following birth.

Unmarried dependent child(ren) includes:

- a son, daughter, or foster child who depends upon the Covered Employee for support and maintenance (If child has coverage through any other plan, including a state or federal plan, due to their status as a foster child, this plan will be secondary for Benefits to the other plan.); stepchild if such stepchild depends on the Covered Employee for most of his support and maintenance; and other children as depend upon the Covered Employee for support and maintenance;
- the child of a Domestic Partner or Partner through civil union;
- children for whom the plan Participant, Spouse, Partner through civil union or Domestic Partner has been appointed legal guardian by a court; and
- legally adopted children. A child will be considered legally adopted from the time the child is placed in the home for the purpose of adoption if the employee is legally obligated to provide full or partial support, whether or not a final adoption order has been issued.

Eligible Employee. An employee, as described in Chapter 2 of this summary, subject to the restrictions delineated in other sections of this summary.

Eligible Expense. Expenses for services or supplies, but only to the extent that: (1) they are Medically Necessary, as defined in this chapter (Chapter 9) of this summary; (2) the services or supplies are not excluded, as provided in the Exclusions chapter (Chapter 6) of this summary; and (3) the General Lifetime, Limited Lifetime, and/or Annual Maximum Benefits for those services or supplies has not been reached. Eligible Expenses are limited to Reasonable and Customary charges as defined in this chapter.

Eligible Mental Health and Substance Abuse Expenses. Expenses for services payable under the mental health and substance abuse benefit of a plan option, but only to the extent that: (1) they are Medically Necessary, as defined in the Definitions chapter (Chapter 9) of this summary; (2) the services are not excluded, as provided in the Exclusions chapter, (Chapter 6) of this summary; and (3) the General Lifetime, Limited Lifetime, and/or Annual Maximum Benefits for those services has not been reached. Eligible Expenses are limited to Reasonable and Customary charges as defined in this chapter.

Eligible Medical Expenses. Expenses for services or supplies payable under the medical benefit of a plan option, but only to the extent that: (1) they are Medically Necessary, as defined in this chapter (Chapter 9) of this summary; (2) the services or supplies are not excluded, as provided in the Exclusions chapter (Chapter 6) of this summary; and (3) the General Lifetime, Limited Lifetime, and/or Annual Maximum Benefits for those services or supplies has not been reached. Eligible Expenses are limited to Reasonable and Customary charges as defined in this chapter.

Eligible Pharmacy Expenses. Expenses for prescription drugs payable under the pharmacy benefit, but only to the extent that: (1) they are Medically Necessary, as defined in this chapter (Chapter 9) of this summary; (2) the drug is not excluded; and (3) the Limited Lifetime Benefit for the prescriptions in question or the General Lifetime limit has not been reached.

Emergency Medical Condition. An Emergency Medical Condition means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the Member's physical or mental health in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction or any bodily organ or part.

Employee's Eligibility Date. The latter of the date of employment or the day after any applicable Waiting Period ends.

Enrollment/Change Application. A form, either paper or electronic, provided by the Department of Personnel for the purpose of enrolling or changing the enrollment status of employees, Eligible Dependents or Covered Dependents. Proper completion of the form is required before any action regarding enrollment status can take place.

Exclusions. Specific conditions, circumstances, and limitations, as set forth in Chapter 6 of this summary, for which the plan does not provide plan Benefits.

Hospital. An Acute Care facility as defined by the American Hospital Association. However, in no instance will the term "Hospital" include any institution or part thereof which is used principally as a rest or nursing facility for the aged, chronically ill, convalescents, or substance abusers, or a facility providing primarily custodial, educational or rehabilitation care.

Illness/Injury. Bodily or mental disorder of any kind. All such disorders due to injuries sustained by a person in one accident shall be considered one illness. Any such disorder that is the same as, or is related to, another existing or previously existing disorder shall be considered with that disorder as one illness.

Incapacitated Child. An unmarried dependent child who is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy or physical handicap and who became so incapable prior to attainment of age 19 (or age 23 while covered under the plan) and who is chiefly dependent upon the employee for support and maintenance. The plan may require reasonable periodic proof of the continuing incapacitating condition no more frequently than once every year.

Initial Enrollment Period. The 60-day period commencing with the Date of Hire and ending on the 59th day following the Date of Hire.

In-Network Provider. A Provider who has an agreement with the Plan Administrator and/or designee.

Inpatient. A patient at a facility who is admitted and incurs a room and board charge. The length of an Inpatient stay is computed by counting either the day of admission or the day of discharge, but not both.

Inpatient Substance Abuse Residential Treatment/Rehabilitation Facility. An institution (other than a Hospital) established to care for and treat those who need inpatient care due to alcoholism or narcotism. The institution must be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located. It must keep daily records on all patients.

Maximum Out-of-Pocket Expense. The sum of Deductibles and Coinsurance dollar limits. Maximum Out-of-Pocket Expense limits may be set for individuals and families for both in-network and out-of-network care. When the Maximum Out-of-Pocket Expense limit is reached, the plan may pay 100% of any additional Eligible Medical Expense for the remainder of the Plan Year, subject to other plan limitations. Any expenses for services and/or supplies not covered by the plan (including care for which Prior Authorization was not obtained) and all charges in excess of Reasonable and Customary do not count toward the Maximum Out-of-Pocket Expense.

Maximum Plan Benefits. The maximum amount of Benefits payable by the plan for Eligible Medical Expenses incurred by Member. The plan has three types of Maximum Plan Benefits:

- **General Lifetime Maximum Benefit.** The maximum amount of Benefits payable for all Eligible Medical Expenses incurred during the entire time a Member is covered under this plan. If a Member terminates coverage and re-enrolls one or more times in the plan, the Benefits paid for any period of enrollment are applied toward the Lifetime Maximum Benefit. The plan will not pay any further plan Benefits for a Member once the plan has paid the General Lifetime Maximum Benefit for that Member. (The General Lifetime plan Benefit does not denote, nor should it be considered to denote, any obligation by the plan to pay any Benefits for the lifetime of the Member.)
- **Limited Lifetime Maximum Benefit.** A maximum amount of Benefits payable, or quantity of services or supplies a Member may receive for specified covered services and supplies, during the entire time the Member is covered under this plan. Limited Lifetime Maximum Benefits are provided in the Benefit Summary. If a Member terminates coverage and re-enrolls one or more times in the plan, the Benefits paid or the quantity of services or supplies covered for the specified covered services and supplies for any period of enrollment are applied toward the Limited Lifetime Maximum Benefit. Once a Member has received a Limited Lifetime Maximum Benefit for a specified set of covered services and supplies during his lifetime, the plan will not pay any further plan Benefits for those services and supplies. The Limited Lifetime Maximum Benefits are not mutually exclusive of the General Lifetime Maximum Benefits; all Limited Lifetime Benefits are applied to the General Lifetime Maximum Benefits. (The Limited Lifetime Benefit does not denote, nor should it be considered to denote, any obligation by the plan to pay any Benefits for the lifetime of the Member.)
- **Annual Maximum Benefits.** A maximum amount of Benefits or quantity of services or supplies a Member may receive each Plan Year for specified covered services and supplies. Once the Member has received the Annual Maximum Benefits for any specified covered services and supplies, the plan will not pay any further plan Benefits for the specified covered services and supplies for the balance of the Plan Year. Annual Maximum Plan Benefits are provided in the Benefit Summary. The Annual Maximum Benefits are not mutually exclusive of General Lifetime Maximum Benefits or Limited Lifetime Maximum Benefits. Annual Maximum Benefits are applied to both Lifetime Maximum Benefits.

Medical or Scientific Evidence. Medical or scientific evidence means that which is found in:

- peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts, and that submit most of their published articles for review by experts who are not part of the editorial staff;

- peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Library of Medicine of the National Institutes of Health for indexing in Index Medicus, Exerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
- medical journals recognized by the federal Secretary of Health and Human Services, under section 1861(t)(2) of the federal Social Security Act;
- the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Healthcare Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, the Centers for Medicare and Medicaid Services, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
- peer-reviewed abstracts accepted for presentation at major medical association meetings.

Medically Necessary/Medical Necessity. Healthcare services and supplies, including diagnostic testing, preventive services and aftercare, appropriate in type, amount, frequency, level, setting and duration to the Member's diagnosis or condition, and which are required for purposes other than the comfort and convenience of the Member or a Provider. Medically Necessary care is consistent with Medical or Scientific Evidence and guidelines or parameters resulting from such evidence, or, in the absence of such, care which is generally accepted by physicians in the same or similar general specialty as used to typically treat or manage the diagnosis or condition, and is clinically demonstrated to:

- help restore and maintain a Member's health; or
- prevent deterioration of or palliate the Member's condition, or
- prevent the reasonably likely onset of a health problem in a Member or detects an incipient problem.

Medically Necessary care does not include services and supplies that are more than those required to meet the basic health need of the Member.

Even if a Provider prescribes, performs, orders, recommends or approves a service or supply, it might not be considered Medically Necessary. The final determination of Medical Necessity rests with the Plan Administrator.

Member. An employee or Eligible Dependent enrolled in the plan.

Mental Health Residential Treatment Center. An institution which (a) specializes in the treatment of psychological and social functional disturbances that are the result of mental health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program under the supervision of physicians; (c) provides 24-hour care in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Residential Treatment Center when they are a registered bed patient in a Residential Treatment Center upon the recommendation of a physician.

Mental Health Residential Treatment Services. Services provided by a Participating Provider for the evaluation and treatment of psychological and social functional disturbances that are a result of a subacute mental health condition.

Network Provider. A Provider who has an agreement with the Plan Administrator or designee.

Nonparticipating Provider. A Provider who does not have an agreement with the Plan Administrator or designee.

Out-of-Network Provider. A Provider who does not have an agreement with the Plan Administrator or designee.

Outpatient. A patient who receives services from a Provider while not an Inpatient.

Participating Provider. A Provider who has an agreement with the Plan Administrator or designee.

Partner. Domestic Partner or Civil Union Partner.

Plan Administrator. The State of Vermont except to the extent the state has delegated such duty to a contractor or contractors. For healthcare services and supplies for which the state purchases insurance coverage, the insurer is the Plan Administrator.

Plan Year. The 12-month period from January 1 to December 31.

Premium. The amount payable in order to receive the coverage described in this summary.

Prescription Drugs. Drugs that are:

- prescribed by a Provider who holds a license to prescribe from the Drug Enforcement Administration (DEA);
- FDA-approved; and
- approved by the Plan Administrator for reimbursement for the specific medical condition being treated or diagnosed.

Prior Approval/Prior Authorization/ Pre-Certification. An authorization that must be obtained from the Plan Administrator before receiving specified covered services. Failure to obtain approval/authorization/ certification before receipt of these specified services may result in reduced or denied Benefits.

Provider. A duly licensed and/or certified practitioner (means approved by the state in which they practice) only as listed below:

- Audiologists
- Chiropractors
- Christian Science Nurses and Practitioners (only as listed in the *Christian Science Journal*)
- Independent Clinical Laboratories
- Mental Health and Substance Abuse Professionals:
  - Clinical Mental Health Counselors
  - Clinical Psychologists
  - Clinical Social Workers
  - Psychiatric Nurse Practitioners
  - Licensed Alcohol and Drug Abuse Counselors
- Nurses:
  - Certified Nurse Midwives
  - Certified Registered Nurse Anesthestists
  - Licensed Practical Nurses (LPN)
  - Registered Nurses (RN)
  - Nurse Practitioners
- Optometrists
- Physicians – Medical Doctors (MDs) and Doctors of Osteopathic Medicine (DOs)
- Physician's Assistants
- Dentists – Doctors of Medical Dentistry (DMDs) and Doctors of Dental Science (DDSs)
- Therapists – Occupational, Physical and Speech
- Podiatrists
- Facility, Durable Medical Equipment supplier, pharmacy or other entity or professional that is:
  - approved by the Plan Administrator;
  - licensed and/or certified where required; and
  - acting within the scope of that license and/or certification.

Reasonable and Customary (R&C) Charges. Reasonable charges are those that are customary and justifiable considering the resources consumed in the provision of the service or supply. Customary charges are those that fall within the range of charges for a similar service or supply billed by Providers in the same geographic area.

Reasonable and Customary Charge determinations are made by the Plan Administrator or designee using published data provided by nationally recognized organizations such as the Health Insurance Association of America (HIAA).

The term geographic area as used above means a county or larger area which provides a statistically valid base from which to ascertain an 80th percentile customary and reasonable charge. The maximum Eligible Expense for a Nonparticipating Provider is set by the plan at the 80th percentile of the R&C Charges. If a Nonparticipating Provider bills less than the 80th percentile of the R&C Charges, the Eligible Expense is the billed charge.

For Participating Providers, R&C Charge is an agreed upon rate which may be established in a fee schedule or determined via an agreed upon calculation. When a Benefit is specified in the Benefit Summary (e.g. 70%), it means the stated percentage of the agreed upon rate for Participating Providers. For Nonparticipating Providers, it means the stated percentage of billed charges or the stated percentage of the 80th percentile of R&C Charges, whichever is less.

Special Enrollment. Enrollment outside the Annual Open Enrollment Period or the Initial Enrollment Period.

Special Groups. The Vermont State Employees' Association, Inc., the Vermont Historical Society, the Vermont State Employees' Credit Union and the Vermont Council on the Arts.

Spouse. A person legally married to an employee and not legally separated from the employee.

State. State of Vermont.

Student Certification/Verification Form. A form which must be completed each year for Eligible Dependents over the age of 18 that verifies a Covered Dependent's status as a full-time student. Failure to return the form to verify full-time student status will result in the termination of coverage.

Subrogation. The right of one party to be substituted in place of another party in a lawsuit. A health plan typically subrogates when third party liability is potentially associated with an injury or illness so the plan may recover medical Benefits paid if a Member or former Member recovers any amount from a liable third party.

Thirty-day Waiting Period. The 30-day period commencing on the Date of Hire and ending on the 29th day following the Date of Hire.

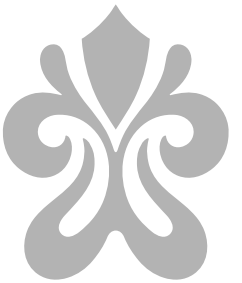
Totally Disabled. The inability of a Covered Employee or an adult Member who is/was employed to engage in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit.

Non-working Members shall be deemed Totally Disabled if they cannot perform the normal activities or duties of a person of the same age and gender.

The Totally Disabled Member must be under the regular care of a physician.

Urgent Care/Urgently Needed Care. Health services that are necessary to treat a condition or illness of a Member that if not treated within 24 hours presents a serious risk of harm.

Waiting Period. A time during which an employee is employed by the state or a Special Group but is not eligible to be covered by the plan.



Statement of Rights Under the Newborn's and Mothers' Health Protection Act

Under the Health Insurance Portability and Accountability Act of 1996, the plan generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

Vermont health coverage guidelines require the availability of certain services to all mothers and newborns for six weeks following delivery. These services include follow-up on discharge instructions (e.g. newborn feeding, cord care and recognition of signs of common newborn problems) and lactation training. Services may be provided by phone, by home visits or in a Provider's office.

If a newborn is discharged at less than 24 hours of age, an examination of the newborn within 48 hours of birth is strongly recommended. If an examination does not occur, phone contact is highly recommended and an assessment made regarding the need and timing of future care. (For further information, see Bulletin 114 (Revised), Maternity Stays Guideline of the Vermont Department of Banking, Insurance, Securities and Healthcare Administration).

While this plan requires notification to the plan of pregnancy in advance of an admission, a Provider does not need to obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable). If a Member's length of stay will exceed the above periods, the Plan Administrator must be contacted. The plan may not provide Benefits for a length of stay in excess of the above periods unless the stay has been approved prior to the end of the above periods.

Post-Mastectomy Services and Supplies

Under the Women's Health and Cancer Rights Act of 1998, Benefits are provided for breast reconstruction following a mastectomy, including reconstruction of a breast on which a mastectomy was not performed in order to produce a symmetrical appearance. Coverage of prostheses and treatment of physical complications of a mastectomy, including post-surgery lymphedema, is also provided.

Cancer Treatment

As required by State of Vermont law (8 V.S.A. § 4088b and Reg. H-2001-04), this plan covers Eligible Expenses incurred as the result of Routine Patient Care Services provided to Members who participate in Approved Cancer Clinical Trials conducted under the auspices of the Vermont Cancer Center at Fletcher Allen Healthcare, the Norris Cotton Cancer Center at Dartmouth-Hitchcock

Medical Center or approved clinical trials administered by a Vermont Hospital or its affiliated, qualified Vermont cancer treatment Providers as long as the Routine Patient Care Services provided are not inconsistent with the terms of this plan.

For the purposes of this section only, Routine Patient Care Services means Medically Necessary services that are provided in conjunction with an Approved Cancer Clinical Trial. They include physician services, diagnostic and laboratory tests, Inpatient care, and other services provided during the course of treatment in an Approved Cancer Clinical Trial for the condition which qualifies a Member for inclusion in an Approved Cancer Clinical Trial or for a complication of the treatment provided during the trial which is consistent with the standard of care for that condition or complication and would be covered even if the patient were not enrolled in an Approved Cancer Clinical Trial.

Routine patient care services do not include:

- the costs of investigational new drugs not approved for market for any indication by the FDA or the cost of any drug being studied under an FDA-approved investigational new drug exemption for the purpose of expanding the drug's labeled indications;
- the costs of non-healthcare services that may be required as a result of the treatment being provided for the purposes of the Approved Cancer Clinical Trial;
- the costs of services that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis and performed specifically to meet the requirements of the Approved Cancer Clinical Trial;
- the costs of any tests or services performed specifically to meet the needs of the Approved Cancer Clinical Trial protocol;
- the costs of running the Approved Cancer Clinical Trial and collection and analysis of data;
- the costs associated with managing the research associated with the approved clinical trial;
- costs for non-investigational treatments or services that would not otherwise be covered under the patient's health benefit plan; or
- any product or service paid for or supplied by the trial sponsor.

Disclaimer

The State of Vermont intends that the terms of the plan described in this summary, including those terms related to coverage and Benefits, are legally enforceable, and that this plan is maintained for the exclusive benefit of members, as defined by law.

Every effort has been made to make the information contained in this summary reflect the information contained in the detailed Plan Document. If any information in this summary is in conflict with the provisions of the Plan Document or the contracts established with administrators and insurers to provide Benefits, or if any provision is not covered or only partially covered in this summary, the terms of the Plan Document and the contracts will govern in all cases.

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Quick Reference Guide

General Benefit Information

Enrollment/Eligibility Questions and Problem Resolution:

Employee Benefits and Wellness Division
Department of Personnel
144 State Street
Montpelier, VT 05620-1701
(802) 828-0648
(802) 828-3455

Mental Health and Substance Abuse Benefits

Claims Information and Appeals:

CIGNA Behavioral Health
Appeals Coordinator
P.O. Box 46270
Eden Prairie, MN 55344
(800) 926-2273

Pharmacy Benefits

Claims Information and Appeals:

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873
(800) 550-8090
www.express-scripts.com

Medical Benefits

You can get answers to many of your questions including:

- The status of a claim payment
- How to find or change primary care Providers
- How to request new ID cards

online at **www.cigna.com.** The information above, plus the status of a medical referral or authorization, can also be obtained by calling:

(800) 351-8513

General Correspondence or to Submit Out-of-Network Claims:

CIGNA HealthCare
PO Box 5200
Scranton, PA 18505-5200

SelectCare Claim Appeals:

CIGNA HealthCare
National Appeals Unit
PO Box 5225
Scranton, PA 18505-5225
(800) 351-8513